WHISTLEBLOWING AND RETALIATION IN THE DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES

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WHISTLEBLOWING AND RETALIATION IN THE DEPARTMENT OF VETERANS AFFAIRS

THURSDAY, MARCH 11, 1999

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:40 a.m., in room 334, Cannon House Office Building, Hon. Terry Everett (chairman of the subcommittee) presiding.

Present: Representatives Everett and Brown.

OPENING STATEMENT OF CHAIRMAN EVERETT

Mr. EVERETT. The hearing will come to order.

Good morning. This Oversight and Investigation Subcommittee meeting is to examine whistleblowing and retaliation of the Department of Veterans' employees—in the department—by the Department of Veterans Affairs and how they handle that.

This subject has been a matter of bipartisan congressional concern for a long, long time. In 1992, the then chairman John Conyers of the Committee on Government Operations issued a report—that is Report 102–1062—with a section entitled "The DVA, Department of Veterans Affairs, discourages the reporting of poor quality care by harassing whistleblowers or firing them."

The report went on to say that according to Tom Devine, the director of the Government Accountability Project, the Department of Veterans Affairs is a leader on the merit system anti-honor for one simple reason: free speech repression has been a way of life at this agency.

The subcommittee's investigation of the treatment of whistleblowers by the DVA confirms this characterization—honest employees who have had their jobs eliminated and their lives destroyed because they attempted to expose poor patient care. The Conyers report is no longer readily available, so the subcommittee has made copies and placed them on the table with the witness statements.

The substance of the entire report is depressingly similar to statements we will hear today.

Whistleblowing by its nature usually involves rank and file or middle level employees, those who are least able to protect themselves against retaliation. Whistleblowers who expose fraud, waste and abuse in government and employee rights to make claims are supposed to be legally protected by a number of federal laws, including the Whistleblower Protection Act.

These activities are very much in the public interest and ultimately serve to protect our veterans from indifferent service or poor medical care and waste of money.

Whistleblowing and filing complaints often embarrasses people in authority by revealing their misconduct or mismanagement. Unfortunately, we know that on occasion they retaliate against whistleblowers, even though it is a prohibited personnel practice under federal personnel law and supposedly a serious violation of civil service merit principles.

The subcommittee wants to know what the VA's whistleblowing protections are for its employees and what the level of employee confidence is that they will be protected. This is another hearing about accountability in the VA.

We have had previous hearings about sexual harassment and mismanagement. I can assure everyone that the subcommittee will have more hearings on accountability at the VA during this Congress.

My concerns about the VA culture of tolerating favoritism, cronyism, harassment, and retaliation are a matter of record. The VA has a history of turning a blind eye towards mismanagement and misconduct by senior officials while punishing anyone who dares to speak up. It is a prime example of the good old boy network.

Our witnesses will be Special Counsel, Office of Special Counsel; the VA Inspector General; senior VA officials; six current or former VA employees who have asserted the whistleblowing status and alleged retaliation, one from the Philadelphia VA medical center, two from the Alabama VA medical centers and three from the Columbia, Missouri VA medical center. All witnesses will be under oath.

As might have been expected, since this hearing was announced, additional possible whistleblower cases have come to the subcommittee's attention and we will pursue them. In fact, the subcommittee is monitoring two breaking situations even as this hearing begins, one at the La Jolla VA medical center in San Diego, CA and one at the VA outpatient clinic in Chattanooga, TN. Both situations are being reported by the news media. Inspector general teams are actively investigating them right now and the subcommittee will await the reports.

I now recognize Congresswoman Corrine Brown, our subcommittee's ranking Democratic member, and welcome her to that post.

OPENING STATEMENT OF HON. CORRINE BROWN

Ms. BROWN. Thank you, Mr. Chairman. First of all, I would like to submit the Honorable Lane Evans' statement for the committee.

Mr. EVERETT. Without objection.

Ms. BROWN. Thank you.

[The prepared statement Congressman Evans appears on p. 56.]

Ms. BROWN. Thank you, Mr. Chairman, for holding this hearing on whistleblowers.

We need to protect employees who uncover threats to the safety of our veterans or crimes or bad management. Good administrators know that it is better to listen to whistleblowers who are mistaken than to silence the ones who are right.

We are here today to examine what progress the VA has made since it came under the law that protects whistleblowers nearly a decade ago.

I am interested in today's testimony. It is important that this hearing stay focused on the issue of whether the whistleblowers have been punished rather than on the substance of what they have revealed. We are limited today to issues of retaliation. It does not matter whether the whistleblowers are right or wrong. They cannot be punished for speaking out.

Congress can measure the effectiveness of whistleblower protection primarily where it fails. That is, VA has no statistics on how often an employee says, "Boss, we have a problem," and the boss calls a meeting and gets the problem resolved.

We have two ways to measure how well whistleblower protection works. One is whatever information we can get from the Office of the Inspector General, the Office of Special Counsel and the Merit Systems Protection Board. The other is to listen to whistleblowers who feel the system has failed them.

VA has some of the finest, most dedicated employees in the world. They must be confident that they can go up the chain and report incidents of mismanagement, fraud or other crimes or breach of patient safety without fear of reprisal.

I am looking forward to hearing some day that VA has awarded a plaque or a promotion to a whistleblower for saving lives or money. Perhaps that has already happened.

Today we will listen to the kind of stories we hate to hear. That is part of why we were elected.

Thank you, Mr. Chairman.

[The prepared statement of Congresswoman Brown appears on p. 52.]

Mr. EVERETT. I would like to congratulate my ranking member on that excellent statement, and we will proceed.

I would like to welcome all the witnesses testifying today. I recognize some of our witnesses are taking time from their daily lives and have had to travel some distance to testify.

I would like to thank all of you in advance for your personal sacrifices. Because of the sensitive nature of today's testimony, I would like to have the witness panels sworn in for their testimony.

I ask each witness to limit their oral testimony to 5 minutes. Your complete written statement will be made a matter of record.

I ask that we hold our questions until the entire panel has testified.

At this time, I would like to welcome and recognize the Honorable Elaine Kaplan, Special Counsel to the Office of Special Counsel.

[Witness sworn.]

Mr. EVERETT. We are very much appreciative of your participating in this hearing. Hearing your views on whistleblowing in the Federal Government of is of great interest and concern to the veterans, thousands of VA employees, and the general public and will be most helpful to this subcommittee. We thank you for your testimony now.

TESTIMONY OF ELAINE KAPLAN, SPECIAL COUNSEL, OFFICE OF SPECIAL COUNSEL; ACCOMPANIED BY RUTH ROBINSON ERTEL, ASSOCIATE SPECIAL COUNSEL FOR INVESTIGATION, U.S. OFFICE OF SPECIAL COUNSEL

Ms. KAPLAN. Thank you, Mr. Chairman, and good morning. I appreciate having the opportunity to testify here today. I am going to summarize and amplify my written statement and ask that it be included in full in the hearing record.

Mr. EVERETT. Without objection.

Ms. KAPLAN. The Office of Special Counsel is an independent federal agency whose basic mission is to protect federal employees and job applicants from prohibited personnel practices, especially reprisal for whistleblowing.

We receive, investigate, and prosecute complaints of reprisal for whistleblowing before the Merit Systems Protection Board. We have the authority to seek a stay of a personnel action on behalf of an individual who claims reprisal.

We can secure corrective action such as back pay or reinstatement, and we can also seek in appropriate cases an order of discipline against agency officials who commit acts of reprisal.

By design, Congress made our agency a neutral body and, as such, we represent neither the complainants nor the agencies. Our client is the merit system.

I was sworn in as Special Counsel in May of 1998 to serve a 5-year term. One of my primary goals for the office is for federal agencies, employees and managers, to come to understand and appreciate our role as an impartial advocate for the merit system.

I am very anxious to reduce our backlog of cases, to shorten the length of time it takes for us to complete an investigation, and also to increase the aggressiveness of our efforts to prevent retaliation against whistleblowers who we all agree play such a key role in promoting the public good.

Now, to do our job effectively, we obviously need the cooperation of other federal agencies. In principle, clearly, the interests of the Office of Special Counsel and of the employing agencies should be the same. All federal agencies should be interested in correcting and preventing illegal personnel practices.

In practice, of course, this is not always the case. Sometimes we encounter resistance from other federal agencies or, in many other cases, particularly out in the field, simple ignorance about what our work is and our authority.

At the present time, we do enjoy excellent relationships with some federal agencies and let me just publicly single out the Department of Defense, the Army and the Navy, as examples of agencies that work closely with us as partners.

Each of these agencies has designated agency liaisons that we contact at the beginning of one of our investigations. They help us coordinate the investigation and they often play an active role in brokering settlements and achieving corrective action on behalf of injured employees.

Over time, we have grown to trust these liaisons because they have proven to us that they share our interest in correcting illegal personnel actions at their agencies.

We are now considering establishing a more formal agency liaison program. We want to create a process where we will train agency liaisons and enter into a formal agreement about our respective roles.

Now, establishing a program like that at decentralized agency like the VA would present a very formidable challenge because in our present day liaison programs, our contacts have influence on field activities and they are very effective in convincing the field offices to take appropriate action.

In order to replicate that at the VA, presumably VA's headquarters would have to take a leading role in working with its field offices and its medical centers.

Mr. Chairman, in 1994, the Congress passed legislation designed to strengthen the Whistleblower Protection Act. The legislation did several things that should be of interest to the committee today.

It expanded whistleblower protection to cover approximately 160,000 new employees, including 80,000 Title 38 VA health professionals. It increased our authority, duties and responsibilities and it also gave all federal agencies the statutory responsibility to advise their employees about their rights under the Whistleblower Protection Act and it directed that the Office of Special Counsel play a consultative role in that process. That is in the law already at 5 U.S.C. 2302(C).

It appears that many federal agencies, including the Veterans Administration, have failed to implement this key statutory educational responsibility in a systematic fashion.

Today, when a new employee enters the workforce, they are usually given a packet of material that tells them about government ethics laws, the Family and Medical Leave Act, flexi-time and other employment-related matters, but I have not yet in my experience met a government employee who received a packet of information regarding prohibited personnel practices or their rights under the Whistleblower Protection Act.

We think education is very important and one of my goals is to increase our outreach efforts and to do more to help agencies meet their statutory responsibility to educate their employees.

We are embarking now on what I hope will be a successful partnership with the Customs Service, for example. The Customs Service recently mailed one of our informational brochures to each of its employees with their pay stubs. They have brought us in on plans to conduct training of their employees and we are planning meetings with their legal representatives that we hope will foster further cooperation.

Customs has undertaken these efforts at the direction of the new Customs commissioner, who wants to change the culture of the workforce and ensure full protection for whistleblowers. I applaud his initiative and I hope that it will inspire similar efforts by other agencies.

In closing, now let me offer a few comments as they pertain to the Veterans Administration.

The bulk of the complaints that we receive concerning VA employees involve either medical centers or hospitals. One issue that the committee might want to explore is what sort of training is provided to the VA medical personnel officers and medical center di-

rectors concerning prohibited personnel practices and the Whistleblower Protection Act. Are the centers being run by directors with a medical background but no personnel training?

These are important questions for the committee, as I am sure you understand, because whistleblower disclosures involving the VA health care system very frequently involve very serious public health issues.

And I notice, Mr. Chairman, that in the VA's response to your letter to the agency it committed to take certain steps to help educate its workforce about whistleblower protection. I want to state for the record here that we would welcome the opportunity to work with the VA in establishing whistleblower awareness and prohibited personnel practice training programs.

We would also welcome its cooperation in establishing a liaison program with the Office of Special Counsel and we also look forward to continuing to work with your committee, Mr. Chairman. And, again, thank you for giving us this opportunity to testify.

[The prepared statement of Ms. Kaplan appears on p. 57.]

Mr. EVERETT. Thank you very much. I note with interest your statement that OSC has jurisdiction over whistleblowing cases involving danger to the public health or safety. I daresay that not many Veterans Administration employees would think of OSC in that context, if they even know who OSC is.

What has been OSC's experience with VA in terms of cooperation in comparison, say, with the Department of Defense and other agencies you cited as examples of agencies that work as partners with you?

Should I infer from your testimony that liaison with the VA could use improvement?

Ms. KAPLAN. I think you could infer that. I mean, we have not really established a successful liaison program and I am not sure—you know, I am new, I just came in in May and it is something that I see as a very important priority.

In fairness to the VA, I do not know if OSC has ever really tried or taken the initiative to suggest that such a program be initiated, but I think it would be very useful at the VA, particularly because of the decentralized nature of their organization.

So I think that would be extremely useful and in terms of outreach, I think you are right, many people do not even know what my agency does and one of the things I am trying to do is to change that and we have done a lot at our agency, but we are a small agency, a very small agency, and we really need the help of the employing agencies like the VA to get the word out about what we do.

Mr. EVERETT. One of our witnesses today tells us that his or her case file with OSC got little action in 4 months and that the witness filed a case with the MSPB in hopes of finding a more responsive forum.

What is the OSC caseload and is OSC's staffing of 24 investigators and ten attorneys adequate to handle the caseload?

The person is often in immediate jeopardy of losing their jobs or harmful retaliation and cannot really wait for somebody to get around to their case.

Ms. KAPLAN. I agree with you absolutely. One thing that has been very frustrating to me and I know to many of my predecessors

is the length of time that it takes us to get closure in a case, to get to the point where we have decided one way or another whether there is a prohibited personnel practice committed.

We have a small staff. There is—we received, I guess, in fiscal year 1998 about 1,800 complaints and we have a staff of—at that point, I think about 86 people. So you could imagine how difficult it is for us to timely conduct investigations, but we are—we are doing our best and we have tried to come up with some procedures that I hope will improve our track record in that regard.

I am familiar with the case to which you refer and I understand the frustration to a certain extent of that complainant, although to be honest with you, her complaint was filed in June, it was referred for investigation fairly quickly, it was referred for investigation in about 2 months, and the complainant's attorney very shortly thereafter—by our standards, anyway, shortly—within about 2 months thereafter told us that the complainant wanted to pursue an individual right of action, so we stopped processing the case.

Now, the statute suggests that we should have at least 240 days to go from start to finish, so that case really did not exceed even our statutory time limit, if you would call it a time limit. But, you know, I am not saying that by way of trying to be defensive because I do understand why complainants do not even want to wait for three or 4 months and that is why they have an individual right of action and it was exercised, I think, in that particular case.

Mr. EVERETT. I can understand that in many cases it has to deal with resources available to you, but there are 200 and how many days?

Ms. KAPLAN. The statute says that we should complete our decision making in 240 days. That is between the complaint and making a determination of whether a prohibited personnel practice has occurred. And, you know, frankly, we do not meet that deadline.

Mr. EVERETT. In other words, you exceed that deadline.

Ms. KAPLAN. Oh, we frequently exceed that deadline.

Now, what I would like to do in cases involving particularly—and what I have been trying to do, in cases involving particularly serious personnel actions is I want to find a way for us to prioritize our cases so that nothing just sits.

So it is something that we are working on and, you know, something that we recognize is a problem and it is frustrating to complainants, frustrating to us and sometimes also frustrating to the agencies themselves.

Mr. EVERETT. But, you know, from the standpoint of the whistleblower, you are talking about 8 months or better, and you cannot even meet that.

Ms. KAPLAN. Well, actually, you know, we can—we do—we do meet it. We do sometimes meet it and we do also have the authority to seek a stay on behalf of a whistleblower and there have been many occasions where we move a case up if someone requests a stay, we look at it more quickly and we make a determination whether we should seek a stay.

We will then go to the agency and say will you stop the personnel action to give us a chance to investigate. That happens with some frequency. Or we can request a stay. So there are mechanisms in place and they are not infallible by any means where we

can and we try to move up and get more quickly to more serious cases.

You know, I could not possibly sit here and tell you that it is acceptable, because it is not, and I was one of the agency's critics before I got there and now I see myself sitting on the hot seat. But we are doing our best.

Mr. EVERETT. I will not go into it any deeper. My concern is if you have enough resources, I mean, still for that employee that is out there hanging in the wind, frankly.

Let me do one more quick question and I think we will have two rounds, if that is agreeable with everybody.

I understand a recent federal court interpretation has effectively narrowed OSC's jurisdiction, resulting in the closing of a number of cases. Please comment on this and how could whistleblower protections be improved.

Was it the Department of Justice that argued to narrow protection for whistleblowers?

Ms. KAPLAN. Well, I think what you are referring to actually is a case involving ironically the VA IG's office, which was a disciplinary action case that the Office of Special Counsel brought against a manager in the VA IG's office for retaliating against one of his subordinate employees and we were successful in that case in obtaining—I think it was a 30-day suspension of the manager involved and the manager appealed the case himself. He was not represented by the Department of Justice.

Ironically, we were represented by the Department of Justice in that case and we argued in that case and we were represented by the Department of Justice, arguing that while we had won that particular case, that the standard of proof that the MSPB had established for disciplinary actions was too stringent.

Mr. EVERETT. We have two federal court decisions and we were not asking about the IG case.

Ms. KAPLAN. I see.

Mr. EVERETT. We were asking about the other one.

Ms. KAPLAN. Okay. Then you are referring then to the Willis case, I believe?

Mr. EVERETT. Right.

Ms. KAPLAN. And the Horton case. I am sorry. I misunderstood. Yes, the agencies were represented by the Department of Justice in that case and successfully argued what I think are probably unreasonable propositions but nonetheless are now the law and those are that if you make a disclosure in the line of duty that it is not protected by the Whistleblower Protection Act.

So, for example, if someone who was a Nuclear Regulatory Commission inspector inspected a nuclear power plant and reported to their superior that there were safety violations, their superior could fire them and they would not be protected by the Whistleblower Protection Act. That was a decision of the Court of Appeals for the Federal Circuit.

Yes, I do believe it was probably urged upon them by lawyers from the Department of Justice representing the agency.

There was also another case which held that when you make a disclosure to the wrongdoer themselves, then that is not protected

by Whistleblower Protection Act. We think that both of those decisions are incorrect.

Mr. EVERETT. Thank you. I would like to recognize my ranking member now.

Ms. BROWN. Thank you, Mr. Chairman.

Good morning. The most important question to me for evaluating how well VA is protecting whistleblowers is this: what figure can you give me on the proportion of complaints filed against the VA that your office has found factual?

Ms. KAPLAN. That we have found substantiation for?

Ms. BROWN. Yes.

Ms. KAPLAN. You know, we do not really necessarily keep our statistics in that way. I can tell you how many cases have been filed against the VA involving whistleblower retaliation and how many of them were investigated or sent for a full investigation.

I cannot tell you necessarily how many resulted in success for the complainant because many of these cases become individual right of action and we stop keeping track.

But for example, the statistics show in fiscal year 1996 we received 86 whistleblower retaliation complaints against the VA; 22 of them, that is one-quarter, were investigated. In 1997, we received 86 complaints of whistleblower retaliation and in 1998 we received 71 complaints of whistleblower retaliation.

In 1998, actually a little bit more than 25 percent of the cases were referred for a full investigation, which indicates that a prima facie case had been made.

Ms. BROWN. And how does this compare with other agencies?

Ms. KAPLAN. You know, I knew someone was going to ask me that and so we spent some time seeing if we could work with our numbers to figure that out and it is very difficult. I cannot give you a reliable figure, and I do not want to be evasive, but it requires comparing really the number of complaints to the population of employees on board at a particular time and I am not even sure if that is completely fair, either, because we have to look at the number of people who are covered by our act. So, you know, I could not give you anything reliable in terms of a comparison.

Ms. BROWN. Well, you mentioned the Department of Defense that you felt worked very closely with you. Can you just give me those statistics?

Ms. KAPLAN. I want to see if I have the Department of Defense. I actually do not think I do, but I could supply them to you after the hearing. And let me say that it is not necessarily just that we will receive fewer or more complaints, it is also how the complaints are dealt with by the agency when we receive them.

The good experiences that we have had with the Department of Defense and the Department of the Army is that we feel that they are very cooperative with us and that, you know, no matter how many complaints we receive, I do not know if you would compare the number of the complaints or the reaction of the agency, that they are cooperative and they help us and that is what we are looking for.

Ms. BROWN. And are you saying that the rest of the agencies or perhaps VA are not as forthcoming?

Ms. KAPLAN. Well, the Defense Department and the Navy and the Army are the best, according to my staff. And there are other agencies that we do not have a good formal relationship with, including, among others, the VA. The VA is not the only one.

And that we have more difficulty because, as I mentioned when I started, frequently the VA—you know, a lot of the complaints arise at the hospitals and the medical centers and they are in small towns and locations and most of these folks do not even know who we are and we call them on the phone and they are resistant. And there is not a lot of coordination. We do not have somebody at headquarters who we can always call, who is working that.

I think the problem can be solved.

Ms. BROWN. Thank you.

And thank you, Mr. Chairman.

Mr. EVERETT. Let me say I appreciate the gentlewoman's line of questioning because the reason it concerns this subcommittee, while I know you do not have jurisdiction over EEO cases, the VA has either the highest or one of the highest instances of sexual or racial harassment in the Federal Government and it is easy for me to wonder if that transfers over to whistleblowing also, if they have one of the highest—but I don't know if it would be possible for you to keep those kind of figures, but it would certainly be interesting.

Ms. KAPLAN. I agree with you. I wanted to work with manipulating our system and our database, and we are adjusting it for the year 2000 and so forth, to try to keep more reliable and more useful statistics, because I think it would be very informative to Congress, not just about the VA, but about other agencies as well, so I think that is a very good suggestion.

Mr. EVERETT. Thank you. And let me point out that we will have additional questions for the record and would ask you to submit answers to those questions within 30 days.

Ms. KAPLAN. I would be happy to answer them. Thank you.

Mr. EVERETT. Thank you for attending.

I would like to recognize and welcome the Honorable Richard Griffin, Inspector General of the Department of Veterans Affairs, and ask him to introduce who he has with him.

Mr. GRIFFIN. Mr. Chairman, Mr. Jon Wooditch is with me. He is the Assistant Inspector General for Management and Administration.

Mr. EVERETT. Thank you.

[Witness sworn.]

Mr. EVERETT. Mr. Griffin, if you will proceed with your statement?

TESTIMONY OF RICHARD J. GRIFFIN, INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JON WOODITCH, ASSISTANT INSPECTOR GENERAL FOR MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS

Mr. GRIFFIN. I want to thank you, Chairman Everett, and the members of this subcommittee for the opportunity to testify on the policies and protections of the Office of Inspector General for employees who engage in whistleblowing activities, as well as for other employees who may be subject to retaliation for filing various types of claims or complaints against the VA.

Since October 1, 1996, the OIG has opened 20 reprisal cases. Of these 20, three were substantiated, six were unfounded, and four remain under review. Of the remaining seven, one sought remedy through the federal courts, one settled with VA management, and five went to the Office of Special Counsel.

Due to resource constraints, the OIG generally has had to limit its investigations to employees who believe they have been retaliated against because they filed a complaint with or provided information to the OIG or to those cases involving senior VA managers.

Whether we accept a case for investigation or not, it is OIG policy to advise all employees of their right to file a complaint with other administrative entities such as OSC, the VA Office of Resolution Management, and the Merit Systems Protection Board.

In cases where our investigation substantiates allegations of retaliation for whistleblowing, we recommend that management take appropriate disciplinary action against the wrongdoer and corrective action to make the employee whole. With our recommendations, we provide VA management with the evidence that supports our findings.

In those cases where VA management takes administrative action, we consider the case closed. This is in accordance with the standard practice in the inspector general community. The decision to take administrative action and the specific action that is appropriate is vested in the management officials who supervise the employee in question.

Because inspectors general are independent of management, they do not recommend specific penalties or disciplinary actions.

The OIG's function of objective oversight makes it especially important that the line between management responsibility and IG oversight responsibility be respected and maintained.

We are aware that some VA employees are reluctant to raise allegations of wrongdoing or cooperate with the IG because they fear reprisal. Fear of reprisal is a natural reaction and will always exist to some degree. However, in my view, fear of retaliation, which has the potential to deter complainants from coming forward with allegations of wrongdoing, is an issue that needs to be continually addressed within VA through timely and credible reviews by the inspector general's office, followed by appropriate administrative actions by the department's managers.

Section 7 of the IG act requires the IG to maintain the confidentiality of employees who file a complaint or otherwise provide information to the IG. This section provides that the identity of the employee cannot be released except if the inspector general deems it absolutely necessary to conduct the investigation.

It is our policy to consider all VA employees who contact us with a complaint as a confidential source unless the employee advises us that he or she does not expect or want to remain confidential.

However, there are occasions where employees would like to remain confidential but the very nature of the complaint makes it impossible to conduct an investigation without explicitly or implicitly identifying the complainant.

For example, an employee may file a complaint containing allegations of mismanagement that the employee previously brought to the attention of VA management. The mere fact that we are inves-

tigating the same allegation could lead management to suspect that employee. Another example involves allegations of retaliation which by their very nature cannot be investigated without revealing the name of the employee.

In such situations as these, it is OIG policy and practice to advise the employee that we cannot guarantee confidentiality if we conduct an investigation and we then allow the employee to decide whether he or she wants us to conduct an investigation or close the case.

In closing, I want to thank the committee for its support, particularly in the fiscal year 1999 budget. The additional resources you have provided will be extremely helpful in improving our ability to issue timely and thorough reports. If these actions are combined with the commitment by the department to have prompt, appropriate administrative actions, we can improve the quality of the workplace for all VA employees and as a result improve the quality of service to our veterans.

That concludes my statement. I will be happy to respond to any questions you may have at this time.

[The prepared statement of Mr. Griffin appears on p. 61.]

Mr. EVERETT. Mr. Griffin, thank you very much.

Similar to my concerns about the Special Counsel's office, it appears to me that the IG office just does not have enough troops to get the job done adequately in handling whistleblowing cases, no matter how strong the commitment to do a good job and no matter how hard you try.

Most VA whistleblower cases come in over the hot line—is that not correct?

Mr. GRIFFIN. That is correct.

Mr. EVERETT. How many each year? How many come over the hot line each year?

Ms. GRIFFIN. We receive roughly 20,000 contacts a year on our hot line. I would not categorize all of those as purely whistleblower type of calls.

Mr. EVERETT. How many employees man the hot line and investigate these cases?

Ms. GRIFFIN. Well, there is an intake unit that staffs the hot line. After they receive a case, if it is a health care related issue that requires the expertise of our health care inspection group, it would be assigned to them; if it is an investigative case that is either criminal or administrative in nature, it would go to a different group of investigative personnel.

Mr. EVERETT. How many cases are referred percentagewise back to the VA for investigation?

Mr. GRIFFIN. In the past year we opened roughly 725 cases and we referred out roughly 85 percent of the total.

Mr. EVERETT. How long does it take you to respond to hot line cases?

Mr. GRIFFIN. Well, some can be responded to very quickly and others which seem to grow—the more you dig, the more you find—can take a number of months.

Mr. EVERETT. An average time would not be appropriate to try to figure?

Mr. GRIFFIN. It is driven by the breadth of the complaint.

Mr. EVERETT. How many allegations of criminal conduct are the OIG unable to investigate each year?

Mr. GRIFFIN. In the past fiscal year, there were several hundred criminal referrals that our criminal investigators could not get to.

Mr. EVERETT. Will those be stacked up and eventually gotten to, or what would be the procedure?

Mr. GRIFFIN. We would try to refer those, if we can, to another law enforcement authority. Some of them will be logged in to our information system and if they connect with something that we are doing subsequently, they could be looked at in conjunction with another initiative.

Mr. EVERETT. I have gone through that line of questions to point out one thing. I think you personally know that I have been personally involved in making sure that your office is beefed up staffwise, but it also is—I realize that these cases can occur in any organization, but what concern is it to you that there is a whistleblower case involving your own office?

Mr. GRIFFIN. Well, if it is the case that was referred to by the Special Counsel——

Mr. EVERETT. Right.

Mr. GRIFFIN. That is a case which dates to 1991, and a case in which, as is the case with all of these hot line-type cases, there was an allegation made and it is being adjudicated in the proper channels. It has been going on for several years and I believe at this point in time, it is in the federal appellate court. It has been going on a long time.

If the question is, am I in favor of retaliating against IG employees? The answer is no. Would I tolerate that? The answer is no.

I have established communications mechanisms in the time that I have been there to ensure that I have open communications with all levels of employees in the IG organization and there will be no problems during my time at the VA IG office.

Mr. EVERETT. The reason I asked that line of questioning is because of the fact that I would hope and I know that you will make sure that this happens, that all employees of the IG's office recognize that among all places that they must not engage in this sort of activity towards employees.

Mr. GRIFFIN. Absolutely.

Mr. EVERETT. I think it is also important to understand that the IG office does not impose discipline on alleged wrongdoers.

What happens if the IG and the VA do not see eye-to-eye on an IG finding of whistleblowing and retaliation?

Mr. GRIFFIN. Well, over the course of the last couple of years, there have been some trip wires put in place in the department to ensure that when there is a disagreement between our conclusions and the conclusions of the officials in the department who have ownership of the employee that there is a formal resolution process in place wherein we would elevate the matter to the deputy secretary level for the deputy secretary's ruling.

That is something that has not happened too frequently, at least in the 17 months that I have been the IG, but it has happened during my time and it is something that is available to us and we will use as we see fit.

Mr. EVERETT. I appreciate your answer. It does concern me from time to time, the appearance of the VA being reluctant to pursue some of these cases.

Ms. Brown?

Ms. BROWN. Thank you, Mr. Chairman.

I have one question and I think you brought it up, that a lot of the employees do not have a lot of confidence in the IG's office. Can you tell me——

Mr. GRIFFIN. Did I say that?

Ms. BROWN. Well, maybe—I thought you alluded to it. Anyway——

Mr. EVERETT. Will the gentlewoman yield?

I can assure you that we get calls on a daily basis that plead with us—on a daily basis—not to reveal their names because they fear retaliation and the inability to protect them.

Mr. GRIFFIN. Sure.

Ms. BROWN. So I would like to know how you have approached this problem and what are you doing to address it and what kind of training or outreach programs do you have?

Mr. GRIFFIN. Again, the problem being people's fear of reprisal when they blow the whistle?

Ms. BROWN. Yes, sir.

Mr. GRIFFIN. I think that all you can do is demonstrate in your actions that you do not compromise people who come to you.

I do not think there will ever be total comfort, whether it is an employee or even people outside of the department who call our hot line. It is human nature that people do not want to be identified as the person who made that contact. It is our policy not to reveal those identities and the only way that we can reinforce that is in practice.

I think part of the problem is that some of these things get so complicated and the time period gets stretched out before any action is taken, if it is appropriate. You have to keep in mind that the majority of the allegations we get are unsubstantiated.

Ms. BROWN. Okay.

Mr. GRIFFIN. And when someone has made a complaint and then months pass and they have not seen any sign of any action being taken toward the person who they feel did wrong, there's a sense of frustration in that they have wasted their time.

Unfortunately, it takes time to properly investigate allegations. And if you are going to bring charges against someone, you need to be certain that you are on solid ground before you bring those charges.

Ms. BROWN. Thank you, sir. What percentage of complaints do you get that you find factual?

Mr. GRIFFIN. I would say in general for our total hot line caseload approximately 25 percent are substantiated; 75 percent are not substantiated.

Ms. BROWN. Thank you.

And thank you, Mr. Chairman.

Mr. EVERETT. I want to thank the panel, and we will now recognize the next panel.

Thank you very much for your appearance.

Mr. GRIFFIN. Thank you very much, Mr. Chairman.

Mr. EVERETT. I would now like to recognize Dr. Christensen, Dr. Adelstein, Dr. Dick from the Henry S. Truman Veterans Medical Center in Columbia, MO; Mr. Bumgardner and Mr. Wilson from Central Alabama Veterans Health Care System; and Ms. Pastor, a former member of the Philadelphia VA Medical Center.

Would you all please stand?

[Witnesses sworn.]

Mr. EVERETT. Before we get started, I might point out that there will be a series of votes, I do not how this may be coming up, in which case we will recess and we will try to get in at least one—I think, Mr. Bumgardner, we will start with you, we will get in as much testimony as we can before the 10-minute bell, at which time we will recess.

Mr. Bumgardner, if you will, please?

TESTIMONIES OF DONALD R. BUMGARDNER, CENTRAL ALABAMA VETERANS HEALTH CARE SYSTEM; KENNETH WILSON, EMPLOYEE, VA MEDICAL CENTER, TUSCALOOSA, AL; JOAN PASTOR, FORMER EMPLOYEE OF PHILADELPHIA VA MEDICAL CENTER; EARL DICK, EDWARD H. ADELSTEIN, AND GORDON D. CHRISTENSEN, HARRY S. TRUMAN VETERANS MEDICAL CENTER, COLUMBIA, MO

TESTIMONY OF DONALD R. BUMGARDNER

Mr. BUMGARDNER. Mr. Chairman, committee members, fellow veterans, and guests, I have been identified as a whistleblower.

I met with Congressman Everett and his district director, Mr. Steve Pelham, in May of 1997. I discussed what I perceived as mismanagement at Central Alabama Veterans Health Care System. Over the next 2 weeks I supplied evidence of——

Mr. EVERETT. Mr. Bumgardner, excuse me, but would you pull that mike up just a little bit, please, sir?

Thank you.

Mr. BUMGARDNER. Over the next 2 weeks I supplied evidence of excessive overtime, sick leave abuse and a master space plan detailing $8 million in renovations, $7.6 million to be done at the Tuskegee campus. Some of these were discussed when the integration was halted on June 10, 1997.

I continued to meet and supply information to Mr. Pelham, the VA inspector general's office and the Federal Bureau of Investigation. I began to be treated differently by higher management. I will only highlight some of the actions that were taken against me.

Mr. Clay, the former director, made references on a local Tuskegee TV station program about a white male who had made allegations against him. The description left no doubt in my mind or anyone else's that he was referring to me.

Secondly, I had my compressed tour abolished.

Third, when I had to go on medical leave for back surgery, the responsibilities for fiscal service operations for both campuses were transferred to the chief of fiscal service at Tuskegee. The memorandum was never rescinded and when I returned from sick leave, my former authority was never returned.

I gave advice to Mr. John Hawkins, former associate director, concerning applicable rules about having a picnic in lieu of an

awards program. When information about the cost of the picnic was leaked, it was canceled. I understand I was one of the people blamed for its cancellation.

I applied for but was not selected for the position of financial manager at CAVHCS. A candidate with less experience but who had previously worked with Mr. Hawkins was selected.

In a December 8, 1997 meeting with Mr. Hawkins, I was given a memorandum reassigning me to the Tuskegee campus as a staff assistant/accountant. When asked for an explanation for the reassignment and relocation, Mr. Hawkins refused to answer me. Mr. Hawkins, standing over me with fists balled, asked whether I would leave or would have to be made to leave. I told Mr. Hawkins I would leave.

On December 9, 1997, all my computer access, with the exception of local e-mail and leave requests, was pulled. The same day, I was informed the door had been removed to the office I was to occupy at Tuskegee.

Management later reversed personnel actions on my former staff when they could not retaliate against me.

Mr. Larry Deal, VISN 7 director, in a July 28, 1997 statement before this committee, stressed that the integration "will improve the quality, access and cost- effectiveness of health care for veterans." He also stated, "We believe that the integration will help eliminate unnecessary administrative and leadership positions at both facilities, thereby freeing up more resources for direct patient care."

He then allowed Mr. Hawkins to recruit and hire six administrative service managers, many from his previous medical center. CAVHCS had expenditures of over three-quarters of a million dollars in salary and relocation expenses.

This was not cost-effective, but it did eliminate Montgomery and Tuskegee service chiefs from leadership positions. Since management could not identify who was or who was not a whistleblower, they elected to replace all of us.

The integration was designed to save precious medical care funds, to expand programs for the veterans we are responsible for serving. As a financial manager, I was a steward of the budget. I was charged with ensuring that the waste, fraud, and abuse statutes were carried out.

I first discussed the overtime usage at Tuskegee with Mr. Clay in January of 1997. Nothing was ever done to decrease its usage. I tried for 5 months to work for change within the organization.

The way the organization was going ahead without any regard for obeying rules and regulations made my decision much easier. I feel I did what was right. I have no regrets.

The Office of Inspector General report on management, clinical and administrative issues at CAVHCS states on page 59, "Based on our analysis of the facts, we concluded that Donald R. Bumgardner's non-selection and permanent change of duties was in retaliation for making protected disclosures and filing an EEO complaint, which are prohibited personnel practices."

I am currently awaiting the resolution of both an EEO and Office of Special Counsel investigation. Without some resolution to either one of these situations, I am not sure what my future holds.

Congressman Everett, I would like to thank you for my invitation to appear here today. You were the only hope many of us had to fight the retaliation and reprisals brought against us. Please understand this thank you comes from many voices that could not be here today.

That concludes my statement.

[The prepared statement of Mr. Bumgardner appears on p. 66.]

Mr. EVERETT. Than you very much, Mr. Bumgardner.

I want to apologize to the panel now, but we do have a vote and it is one of those necessary evils we have up here and I will recess the hearing and we will be back shortly. Thank you.

[Recess.]

Mr. EVERETT. I again apologize. We can get in about 20 minutes, hopefully, before our next—there will be a series of votes after that, which would delay us probably another half-hour.

I would also point out that please do not be alarmed by the absence of members on the panel. This particular committee is made up of, for instance, on this side Mr. Floyd Spence, who is chairman of the House Armed Services; Mr. Stump, who is chairman of a full VA committee; Mr. Buyer, who is chairman of the personnel subcommittee on House Armed Services; and Mr. Lane Evans, who normally attends, is the ranking member on the full VA committee and was a former chairman of this committee; and then Ms. Brown is an important member of the Transportation Committee and they are currently having a vote and markup right now. So it is just the nature of how we have to do things here, but I can assure you that each of these members recognizes the importance of these hearings and your statements.

Mr. Wilson, we will ask you to continue now.

TESTIMONY OF KENNETH WILSON

Mr. WILSON. Mr. Chairman, members of the committee, my name is Ken Wilson. I am presently employed at the VA Medical Center in Tuscaloosa, AL. My federal service consists of 3 years——

Mr. EVERETT. Mr. Wilson, I am sorry. I am going to ask you also to pull that mike up as close as you can get it, please, sir.

Mr. WILSON. My federal service consists of 3 years in the United States Navy and 27 years with the Veterans Administration. I have served in seven VA medical centers and had obtained the title of Chief, Acquisition and Materiels Management Service.

My reason for being here today is to provide a brief synopsis of the events that led to my being eliminated from my career field and being placed in the status of not having a position description nor a defined job assignment.

The VA Medical Center in Montgomery, AL became my duty station in July of 1988. My position as Chief, Acquisition and Materiels Management Service required me to be an integral part of the day-to-day administrative effort to strive to ensure the best possible care for the nation's veterans through support to the clinical care providers at the Montgomery VA.

In this effort, I received numerous outstanding performance awards for my efforts. In 1996, it was determined that the VA Medical Center in Montgomery, AL and the VA Medical Center in

Tuskegee, AL would be consolidated into the Central Alabama Veterans Health Care System.

In late December 1996, my counterpart at Tuskegee left federal service and I was asked to manage both medical centers' logistics operations. In March of 1997, the acting director of the combined centers presented me with an outstanding performance award.

In the fall of 1997, the position I occupied was advertised nationally and I in effect applied for my own job. This process also took place for other service chiefs serving at both VAMCs. I was advised by the associate director that I was not selected for the position.

My question to him was what qualifications did I not possess to be selected or what leadership skills did I not have to be selected. I got no answer except to say that I was fully qualified and he wanted his own man in the job.

I asked what my new job would be, but was not given an answer. I received a memorandum informing me that I would be an administrative assistant to the new chief. In January 1998, I chose to transfer to another VA to remove myself from this situation.

My failure to be selected was and still is the result of my being part of a group of employees who cooperated with the VA IG investigation into the integration and my association with Congressman Everett's Office in the review of this integration process. My nonselection also stems from my not cooperating in the expenditure of funds for a function that violated regulations.

Before my removal as service chief, I was instructed to write a purchase order for a picnic for employees of the combined VA medical centers in Montgomery and Tuskegee. The cost of this picnic would have totaled just under $25,000 for food and entertainment. I informed the associate director that this transaction was illegal and could not be accomplished within the regulations.

I was given a copy of an agreement signed by the associate director that detailed what was to be provided by the vendor and repeatedly told to write this purchase order.

My refusal to act on this matter led to my conferring with the Network Acquisition Office for advice and guidance. The picnic was canceled the day before it was scheduled. This situation lead to my being labeled as not a team player and being against the integration process.

After this incident and numerous others mentioned in the VA IG report took place, a group of employees chose to contact Congressman Everett's office for assistance. To this day, if it had not been for the intervention by Congressman Everett, this situation would have continued to deteriorate and brought down the level of patient care to an unacceptable level.

To this day, the situation at Central Alabama Veterans Health Care System remains unsettled and in turmoil. No end is in sight.

Without reliving all the details of the integration of VA Montgomery and Tuskegee, please allow me to say that there is no provision in the VA system to protect those employees who cooperate with the VA Inspection General. There is no mechanism to stop the injustice to employees who attempt to prevent the gross mismanagement of VA activities. Attempts to make higher level officials aware of the activities fall on deaf ears.

Some Central Alabama Health Care employees chose to resign and find other jobs, some chose to take the early out and reduce their retirement benefits. Others chose to give up their homes, their VA families and seek other VA positions. Some chose to stay and be subjected to a multitude of harassing and embarrassing situations.

Some chose to pursue the EEO system for resolution, some who could afford it chose to hire legal counsel to seek relief. Some chose to walk away and give it up. And some of us still hold out with the faith that our VA system will correct these wrongdoings and compensate those affected by these actions.

To date, the system has managed to lose quite a few dedicated and loyal employees who cannot be replaced easily. The system has completely shattered the pride of many employees that have spent their adult lives in the VA system. The system has not only failed those employees, it has also failed the veterans these employees have served long and faithfully for.

In closing, I would hope that through these hearings that some mechanism will be developed to ensure that the employees of this agency have some avenue of protection and that policies are defined and carried out equally and fairly.

My thanks to the Committee for the opportunity to speak and to Congressman Everett for his role in this situation.

I was asked if I had any reservations about testifying before this committee, my reply was "Gone is my career field, gone is my job, my VA family, my home, and my faith in a system that I have spent 27 years in; what else can I lose?"

Thank you, sir.

[The prepared statement of Mr. Wilson appears on p. 71.]

Mr. EVERETT. Thank you, Mr. Wilson.

Ms. Pastor.

TESTIMONY OF JOAN PASTOR

Ms. PASTOR. Good Morning, Mr. Chairman, members of this committee. I feel honored that you asked me to be here today. I just wish that my invitation were under different circumstances.

I was asked here today to tell you about the retaliation that I experienced after reporting a number of ways my supervisor, W. Bruce Dunkman, M.D., at the Philadelphia VA Medical Center violated federal laws, rules, and regulations and actions that posed a substantial threat to the health and safety of the hospital patients.

I was a research nurse at the Philadelphia VAMC in the Special Cardiology Clinic, working on NIH and pharmaceutical company-sponsored clinical research studies from August of 1995 to May of 1998.

During my tenure, I was harassed, intimidated, slandered, excluded from my job, and ultimately dismissed from my position for trying to help and protect the patients in the clinic.

The retaliation began in August 1996, after a male pulmonary function technician sexually attacked me. My supervisor, Dr. Dunkman, blamed me for the assailant's actions. I informed my supervisor how I felt physically threatened, but he did nothing.

My supervisor never told me about the EEO process, nor did he report this incident to the EEO office or to other management offi-

cials. My supervisor exclaimed that the assailant was a tech that he did not want to lose.

For 6 months, I endured my supervisor's repeated threats of possibly bringing the man that attacked me into my office area. Finally, after my supervisor pounded his fist on the desk and demanded that I leave my office area so the assailant could come over to my area and take over one of my job responsibilities, I went to HR, human resources.

I went to human resources to inquire about other positions within the hospital. The acting HR director asked me why I was exploring new opportunities. I made several disclosures to the acting HR director that included Dr. Dunkman's improper handling of the sexual assault, his practice of repackaging and redistributing drugs from one patient to another and my inappropriate exposure to radiation within the clinical research studies.

The acting human resource director requested that I write a statement summarizing our discussion. I did so in an effort to protect not only myself, but also the patients.

After I delivered my report to HR, the medication redistribution stash was removed from the clinic by a health care team. Dr. Dunkman had been redistributing medications from one patient to another for years.

The medications being distributed in the clinic had already been dispensed to other patients and handled and some were obviously dirty and were expired and were not to be consumed, but Dr. Dunkman distributed the medications to patients anyway. Dr. Dunkman never kept records of the medications he distributed in his redistribution scheme or to whom they were distributed.

At this point, the acting HR director told me that my safety was in jeopardy at the Philadelphia VA and that I should not return to work.

Upon my return to work, I was given an office in the basement without anything to do. I objected to this and decided to return to my previous position, even though no safety measures were afforded me.

When I returned to my office, Dr. Dunkman repeatedly yelled at me to get another job. He ignored me when I asked him questions, told me he was too busy to give me answers to important patient report issues, excluded me from the clinic meetings, and tried to deny paying for graduate school, a benefit agreed upon during my hiring at the Philadelphia VA.

In April of 1997, Ms. Ann Lovell, the radiation safety officer, called me to discuss and determine the degree of my radiation exposure during one of the clinical research studies. Since the RSO was not aware of the research I was doing, we reviewed the informed consents and protocols.

Ms. Lovell and I discovered that the research had not been approved by the radiation safety committee and the biohazard committee.

Mr. EVERETT. Ms. Pastor, I am sorry. I regret that I am going to interrupt you. We will hear the rest of your testimony, but unfortunately I have about 4 minutes to get to the floor.

There will be a series of votes, so we can expect at least a 20-minute delay.

Thank you very much. We are recessed.

[Recess.]

Mr. EVERETT. The committee will come to order.

Ms. Pastor, I again apologize. This is kind of the world we live in up here, but I would like for all of you to know that both staff and the members have already read your statements and this is just a matter of record. So if you will proceed.

Ms. PASTOR. All right.

This was a regulation of the radiation license granted by the NRC and the PVAMC regulation. Since the radiation experts within the hospital had never calculated the dosage of radiation received by the patients in the study, the informed consents either neglected to state or underestimated the amount of radiation that the research patient would receive during the protocols.

After these issues were further investigated, one of the ongoing studies required all 90 hospitals, 30 VA hospitals and 60 non-VA hospitals, conducting that research to change their informed consent to reflect a more accurate calculation of the radiation exposure of the research patients.

In May of 1997, my co-worker and supervisor filed criminal charges against me, charging me with taking patient files, because they could not be located. I was on vacation the day the charges were filed, but was available by phone. When I returned to work the next day, Dr. Dunkman stated that he had filed criminal charges against me for taking missing patient files. I showed Dr. Dunkman that the files were beside the other research files, where they had been for months.

This was only the beginning of Dr. Dunkman's slander campaign. I heard Dr. Dunkman tell a management official that I was psychotic and a co-worker reported that Dr. Dunkman told them that I was crazy.

Dr. Dunkman and my co-worker worked in synergy telling other employees and patients that I was not doing my job and that I was trying to close the clinic.

I was very upset that Dr. Dunkman tried to slander me to cover up his wrongdoing. I only reported his action because the patients' health and safety was at stake.

I went to the PVAMC's medical ethicist to discuss the ethical issues pertaining to the misleading and inaccurate statements contained in the informed consent for the research studies. Although she was outraged that the informed consents were inaccurate and the necessary approvals for the research were not obtained, she said that she could not say anything because she feared losing her job.

In May of 1997, the FDA audited the special cardiology clinical research site. Dr. Dunkman demanded that I only answer yes or no to the FDA investigator's questions.

I continued doing my work during the audit and placed a revised informed consent for one of the research studies in the regulatory binder during the audit, as required by the study's CRAs.

Dr. Dunkman became very upset with me because he thought that the FDA inspector might have noticed the changes in the informed consent regarding radiation and that it had been improperly approved by expedited review.

The investigator also questioned me about the delinquent and absent reporting of patient deaths and serious adverse events in the research study. I fully cooperated with the FDA investigator and showed him how many of the reports had not been filed.

The NRC investigated. The NRC auditor asked me questions about the unapproved clinical research being conducted in the clinic. Although the NRC auditor knew that the violations of conducting clinical research without radiation safety and biohazard committee review and approval was contrary to the NRC license, she warned me that my reporting of these violations would ruin my career, and then referred to the problems that the RSO, Radiation Safety Officer, Ann Lovell, was experiencing for her similar reportings.

In a follow-up letter to me, the NRC stated that clinical research did not fall entirely under their jurisdiction and therefore the FDA would be consulted on some of the issues I had raised. The investigations by both agencies, the FDA and the NRC, are still open on these issues today.

At this time, management knew of my disclosures to the NRC and FDA. Dr. Dunkman, in June of 1997, repeatedly consulted the hospital administrators, director, and human resource personnel to find a way to terminate me. Dr. Dunkman then wrote a memo to Ms. O'Shea, associate hospital director, indicating his wish to eliminate me due to my whistleblowing.

In September of 1997, I was again exposed to radiation without my consent or knowledge. My co-worker left a radioactive blood sample in my office area at the desk where I often sat. This sample not only contained radiation, but was also hazardous waste. Dr. Dunkman did not chastise, discipline, or retrain my co-worker for this dangerous act.

Also in September of 1997, the radiation safety committee met. At the meeting, the chief of radiology yelled at me in front of my peers and management officials to get another job.

Subsequent to the meeting, Dr. Dunkman admitted that he had asked the Chief of Radiology to tell me to get another job. He also asked an outside employee who visited the clinic, a clinical research associate, to tell me to get another job. She told me this in a derisive manner.

Dr. Dunkman again resorted to intimidating me and screamed at me, saying I was only at the Philadelphia VA to collect a paycheck and that I did not want to work. Yet he had been pleased with my performance prior to my making protected disclosures.

To assure that I was adequately performing my duties, I had repeatedly asked for performance appraisals, but I never received one, despite the fact that my co-worker did receive one. Dr. Dunkman explained in a deposition that he did actually prepare one in April, 1997, but that since he could not bear to talk to me to review it, he gave it to the associate director of research to go over it with me, which he did not. Dr. Dunkman never checked to see if I had received it, which I had not. I also requested a job description from Dr. Dunkman, but one was never presented.

Finally, after Dr. Dunkman had had many discussions with Philadelphia VA management about the easiest way to terminate me, the then acting HR director suggested a plan to eliminate my

position by depleting the funds in my supervisor's accounts. Dr. Dunkman then carried out this plan. He requested one of his studies to terminate him as the principal investigator study clinical site. The initial letter from the study, that was amended at Dr. Dunkman's request, indicated this action was being taken due to the ongoing investigations instigated by the research nurse, me.

This sentence was later changed to hide the fact that their actions were in retribution for my voicing concerns about wrongdoing at the Philadelphia VA.

Management officials then falsely asserted that Dr. Dunkman's funds to pay the research nurse salaries were depleted. My co-worker and I were laid off. My co-worker was then rehired, as planned, by Dr. Dunkman prior to the terminations. No effort was made to assist me in obtaining alternative employment, either before or after my termination.

I am now living in the aftermath of having tried to protect my patients' health and welfare. My reports of impropriety and wrongdoing have left me without a job to support myself and have damaged my career irreparably.

I went into nursing to help people. I felt my work in clinical research could accomplish helping millions of people by developing new technology for those of us that suffer with incurable illnesses.

The sick, my patients, committed themselves to me and the medical professionals at the Philadelphia VA medical center. My patients implicitly trusted that their welfare would be protected and the truth about the risks of the research studies would be told to them. From my perspective, this was not happening in the clinic where I worked.

I stood firmly for the rights of the patients and gave them the respect and care that is deserved by any individual, especially our veterans. My efforts have righted some wrongs, but I have suffered greatly for coming forward.

I am here today to ask only one thing of this committee. I ask that the medical professionals who stand up for the patients' rights be protected and not have to suffer. Those who want the truth to be known and try to abide by the government rules and laws set up to protect people should be applauded, not retaliated against and fired.

Remember, we will all be patients some day and will want to commit our trust to our physicians and nurses who care for us. If a whistleblower nurse stands up for our rights, I would hope that we would want them to be praised, and not to have to endure untold suffering, as I have in the past years.

Thank you for your invitation to talk to you today and for your concern for the health and welfare of our nation's employees, patients, and veterans. Your concern should be commended.

Thank you.

[The prepared statement of Ms. Pastor appears on p. 73.]

Mr. EVERETT. Thank you, Ms. Pastor.

Dr. Dick.

TESTIMONY OF EARL DICK

Dr. DICK. Mr. Chairman, my name is Earl Dick. I am a physician at the Harry S. Truman Memorial Veterans Hospital in Columbia,

MO. I am appearing before the subcommittee in an individual capacity.

I am here to speak to the way the VA deals with people such as me. As tragic and illegal as the retaliation and reprisal has been to my career, it is more horrifying to me to recognize that the VA has institutionalized retaliation and reprisal as a way of doing business.

I want to express my appreciation for the invitation to provide my testimony and statement to this subcommittee.

I am here to speak about the reprisals I experienced from officials at the Harry S. Truman Memorial Veterans Hospital and the Department of Veterans Affairs for the disclosures which I have made.

I believe what happened to me and Drs. Adelstein, Christensen, and Simpson represents the culture of retaliation and reprisal used within the VA.

Retaliation and reprisal begins with actions which management perceives to be threatening. In my case, it was the result of my not participating in the cover-up of patient murder in 1992. By September 1992, I was convinced that independent of the excellent medical and nursing care at our facility, that some 11 to 40 patients had been murdered.

Drs. Adelstein, Christensen, Simpson and myself continue to believe that to be the case and as a result of our beliefs and the actions we have taken, all of our careers have suffered.

The agency position has been and continues to be that there is no evidence of murder. In a trial brought against the VA by one of the families, the Honorable Nanette K. Lowery, United States District Judge, stated in her ruling from the bench in August 1998, and I quote, "Finally, I also find that even absent the testimony about codeine, there is sufficient evidence for me to believe, and I do believe, that Nurse Williams killed Elzie Havrum."

The epidemiology of the deaths demonstrated murder and was key to understanding what had happened. I was responsible for the regional site visit team, the FBI and the Assistant Inspector General for Health Care Inspections receiving presentations and explanations of the epidemiology.

As chief of staff, I did not cooperate and support the cover-up, even though from my knowledge of the VA I knew I was placing my career at risk.

I have learned that when detrimental information became public the VA has retaliated against me, as I was the chief medical officer of the facility and thus a traitor to the system, not a team player, for not controlling other professionals and not participating in the cover-up.

Following those disclosures in 1992, I received lowered proficiency reports and continued harassment by then hospital director Joseph Kurzejeski. This culminated in 1994, when I was forced from the position of chief of staff by threats, including the loss of employment, from Mr. Kurzejeski, who was aided by the then dean of the University of Missouri School of Medicine, Lester Bryant. I agreed to become ACOS of Education, Associate Chief of Staff of Education.

In the spring of 1995, I made disclosures to the OIG of the VA of the events that happened in 1992. In May, I learned of a plan to relocate me from my office space, which subsequently occurred. Dr. Bauer continued to provide me lowered proficiency reports.

In August 1995, I made further disclosures by providing a multiring binder which was used at the May 14, 1998 hearing of this subcommittee. That binder contained extensive documentation of the role of Mr. Kurzejeski and region concerning the murders and cover-up to a staff member of this subcommittee.

In the fall of 1995, I received a letter notifying me of a proposed 30-day furlough. To my knowledge, I was the only physician at the hospital to receive such a letter and experienced a brief furlough.

In January of 1996, I was given a copy of the plan to abolish the Associate Chief of Staff Education position.

In August 1996, within 6 weeks of my filing with the Merit Systems Protection Board, I was told by Dr. Bauer of a change in work responsibility, that 90 percent of my time would be as a staff psychiatrist. This proposed change and the plan to abolish the ACOSE position was in fact effected by a series of memoranda from Director Gary Campbell in 1998.

As an active whistleblower in 1997, I cooperated with the Office of Special Investigations of the General Accounting Office in their investigation of the VA OIG report initiated by this subcommittee.

The GAO report, titled "Inspector General Veterans Affairs Special Inquiry Report was Misleading," stated on page 3, and I quote, "Therefore, the special inquiry's conclusion was not supported by work done or evidence collected and is misleading."

The memorandum notifying me of further demotion was transmitted to me prior to my attending the subcommittee's hearing on May 14, 1998 and I believe was part of the VA's response to the highly critical GAO report.

Immediately upon my return, Director Campbell clarified his assignment of me to the mental health service line and the change in my supervisor. He removed the program assistant from my position. Earlier, he had approved my reassignment from the chair of the education council to an ex officio member. I suffered a demotion.

In summary, I made disclosures to the regional site visit team and to the FBI regarding 11 to 40 patient murders at Columbia. I made disclosures to the Assistant Inspector General for Health Care Inspections, the VA Office of the Inspector General, the GAO Office of Special Investigations and to this subcommittee regarding the 11 to 40 patient murders at Columbia and the cover-up of those murders.

As a result, my career has been demolished. The retaliation and reprisals against me have damaged my professional reputation, lowered my proficiency reports, caused me to lose office space, chairmanship of a council, removed my program assistant, and led to my assignment as a mental health physician. Thus, I have suffered a demotion.

Mr. Chairman, my experience is reprisal and retaliation continue even with changes in hospital directors. Thus, VA's statement of new management is and has been meaningless.

Based on my personal experience, I would urge this committee to discuss reform to end the VA culture of reprisal, retaliation, and cover-up. The lowest burden of proof should apply to the whistleblower. The agency burden of proof should be the highest. The agency has far more resources.

Once a congressional committee accepts and uses information from a whistleblower, that person should be protected from reprisal in any form. I believe this should apply to those of us here as well as Dr. Simpson and those who have aided congressional committees in the last 5 years.

In 1994, I sought relief from the OSC, but because the act approving Title 38 employees went into effect in October, 1994 and it was in August, 1994 when I received my problems, the OSC could not deal with them.

My personal experience is such that I have no reason to believe the VA will change its practice of reprisal, retaliation, and cover-up. I can only conclude this represents the culture of the VA. Sadly, I believe change must come to the VA through outside action.

Chairman Everett, there is a price for telling the truth. I and my family have paid an emotional price as well as the loss of income when I was forced from the chief of staff position. I and Drs. Adelstein, Christensen, and Simpson have suffered significant emotional trauma, not only from the retaliation and reprisal, but from the knowledge that these patient murders have gone unacknowledged and free of accountability.

As a result of retaliation and reprisal, I have suffered financial loss of income and cost of defending myself, as have Dr. Adelstein, Christensen, and Dr. Simpson.

Chairman Everett, there is a price for not telling the truth. I believe that the cover-up of these patient murders not only prevented criminal prosecution, but has prevented the hospital and the VA from acknowledging and accepting the responsibility of what occurred.

The families of the veterans are left with continuing uncertainty. Without accepting the responsibility, how are the hospital and the VA able to assure the patients entrusted to it that it will not reoccur?

Chairman Everett, thank you. I would like the committee to know and to remember the cost of truth in the VA is formidable.

[The prepared statement of Dr. Dick appears on p. 80.]

Mr. EVERETT. Thank you very much. Dr. Adelstein.

TESTIMONY OF EDWARD H. ADELSTEIN

Dr. ADELSTEIN. Thank you very much, Mr. Everett and members of the committee. I am a physician, a pathologist, a veterinarian, and deputy medical examiner of Boone County. It has been my pleasant experience in general to work at the VA Medical Hospital, where I have a great deal of affection for the employees and the people we take care of. I have been there since 1972.

I think I would like to address the culture of the VA as it relates to the 1992 deaths and the 1998 decision that was reiterated by Dr. Dick regarding that the VA was found guilty of knowing but not

protecting its patients and that one of the patients indeed had been murdered.

If I was to paraphrase the judge, and having attended the trial, what she would have said was there was a cover-up throughout the VA organization and the FBI's evidence was not believable.

When I came to the VA, the director, Mr. Kurzejeski, was a pretty classical autocratic, erratic guy who essentially worked on the basis of reprisals and on a fear basis. It became fairly clear to me that we have a system where basically everybody understands the rules, the rules being if you tell the truth, you are punished, and if you take part in a thing even as heinous as murder that you are actually recognized as a loyal, valuable employee and you are rewarded.

If Mr. Wilson would have only written the check for $25,000, he would probably be a director today instead of a person without a job. In order to actually change the way we do business, that culture will have to be mightily reversed.

Unfortunately, under the organization of Dr. Kizer, things have not gotten better. His first words that he uttered to the VA employees were "If you think your job is secure, think again." Under that kind of threatening basic philosophy, we enter an area once again where changes come about not through rational decision making, but actually through fear and reprisals.

In the summer of 1992, I was the acting chief of staff when I essentially altered Dr. Christensen's career forever by asking him to review the data of the deaths of the 40 people. He quickly revealed that this was very serious, and the VA sent a blue ribbon panel of people of highly respected chief of staffs and directors to review the data.

When he first walked into the room, which he went into against the advice of the director and with the concurrence of Dr. Dick, he was told a chilling statement which I have never forgotten, which is that "you're a foolish young man for being here today."

And I understood that. I understood exactly what that meant. That meant they all knew—and they were all smart enough to understand the data—they all knew that murders had occurred, they all knew that the statistical data was irrefutable and they all knew that his life would become a living hell because he refused to remain quiet.

We continued to press this issue. Dr. Dick essentially was—essentially his career started on a downhill basis since he facilitated that meeting.

We eventually met with the OIG, Dr. Alastair Connell, in a sort of a secret meeting where he told us all we had whistleblower protection. Obviously, we never had whistleblower protection and in an affidavit he signed he denies that he made that statement.

Because Dr. Christensen forced the issue, the OIG was forced to carry out an investigation and that investigation was extremely frightening to me, although I can tell you that all the people who wrote it, Mr. Trodden, Mr. Kroll, Mr. Lucas, Mr. Cole have all retired, as would seem to be the way one deals when they cover up terrible events.

That report, as you know, was presented before this committee and was found to be not credible. For myself, I simply believe

maybe that was business as usual. That report, when viewed by the GAO, actually determined it was misleading because it never actually investigated whether there was a cover-up, but we from rural Missouri would have used the words "that report was lies, damn lies and dangerous lies," because as far as we could tell, there was never an honest determination.

And I was further fairly uncomfortable that Mr. Griffin, the new person, head of the OIG, essentially supported the old report as pretty much correct with just a few small changes. So we have little reason to believe that things are really changing.

The FBI was brought in and they likewise seemed to be compromised in their ability to deal with the deaths and essentially only after a great deal of pressure generated an unsigned report, in spite of overwhelming forensic evidence leading to the deaths.

During the next period of time to 1998, essentially we suffered a barrage of reprisals, extremely similar to what you have heard here. Campaigns of disinformation. I mean, when everyone comes to the VA, they point me out as someone who is dangerous and someone who is really about to destroy the hospital because we are the truth tellers.

They do the classic things that have been talked about: threats, poor evaluations. Actually, if these people were smarter, I mean, because they are mean, we would be in grave trouble, but fortunately they are just mean and not that smart.

In 1998, I testified both as a deputy medical examiner and as a VA employee in the case of Elzie Havrum versus the VA. I gave really critical damaging evidence. For instance, I pointed out that from Jesse Brown to Dr. Kizer to many people throughout the VA, they were all aware of the deaths, they were well aware, I believe, that they had a serial killer. They refused to take responsibility. They actually turned this nurse loose, where I investigated his performance in local hospitals where more deaths occurred.

The lawyers were extremely upset with my testimony. As a matter of fact, they asked for an immediate transcription of my testimony. I took that not to be a good sign. But since we are truth-tellers, I feared nothing.

Unfortunately, in August of 1998, while I was on vacation, I received a summons that an investigating board was coming to see me regarding allegations of theft of a controlled substance, a charge so serious that it could end my career, a charge so serious that every time I apply for my physician's license I have to document those events that took place.

This allegation was unfounded. It was based on the fact that in 1996, in an issue that had been well reviewed, as a veterinarian and as a humanitarian act I had asked for and received and got permission to use a small amount of euthanol so I could put to sleep a suffering animal after work at my own time and expense. It was not an uncommon process, and I have affidavits from the people documenting those events.

Nevertheless, when this board came during my vacation time, giving me no notice, no chance to prepare a counsel, I was told by Dr. Hoyt, who was the chief radiologist, since I refused to take this seriously that these people had a very substantial agenda, that one of them had confessed to him privately that this was a political

agenda being carried out on a high level and, as a matter of fact, I took opportunity of that to protect myself, they dismissed the charges.

Let me just make some closing statements, that it is no fun—and this is our solution—there is no pleasure in the documentation of wrongdoing. I mean, I think we have all heard that.

Certainly the VA at the highest level must realize they are sitting on a ticking time bomb where if not diffused by honest actions it will be revealed as the largest health care system to be fatally flawed and undeserving of the trust of the patients. This is the best documented case of lying, cover-up perjury and misdoing that I can imagine. We have done enormous amounts of work, I would like to believe, for this committee.

So I ask you in the name of justice to pursue all aspects of these events. I believe a grand jury should be convened, individuals deposed, the truth revealed and punishments levied.

Just like in the series "Happy Days," when the Fonz says to Richie, "Sometimes, you have to fight in order to prove that you're tough." I believe that sometimes this committee will have to fight.

If just one time you can reach in the back, take away—take away the pension from a person who has covered up murder, change the way people think, most of the people in the VA are decent, good people and would rather tell the truth, as a matter of fact, but we have a system where telling the truth is dangerous and lying is the avenue to promotion.

So I ask that you have the courage and, as we would say in rural Missouri, the guts to pursue those actions so these events never occur again.

Thank you.

[The prepared statement of Dr. Adelstein appears on p. 83.]

Mr. EVERETT. Thank you very much. Dr. Christensen.

TESTIMONY OF GORDON D. CHRISTENSEN

Dr. CHRISTENSEN. Mr. Chairman and members of the committee, Dr. Dick and Dr. Adelstein have already established that I was the physician who correctly identified the nurse (as the most likely cause of the unexplained deaths on Ward 4 East at the Truman VA Hospital) and alerted the IG to the cover-up of these deaths. They have also mentioned that the IG performed an investigation and falsely reported that there was no cover-up. That issue has already come up before this committee.

My purpose in reminding you of that is that unlike the Veterans Health Administration under the leadership of Dr. Kizer and unlike the Office of the Inspector General under the former leadership of Mr. Trodden, I speak the truth.

Now let me tell you how the VA treats a truth-teller.

After the 1995 hearing, Dr. Kizer invited me to Washington and offered me the position of Medical Inspector. I would like to have had the opportunity to fix these problems from within, but after discussing the position with personnel at VA headquarters, I concluded Dr. Kizer's offer was dishonest. It appeared to me that Dr. Kizer did not support the Medical Inspector's office and would not hold senior management responsible for their misdeeds, so I declined the position.

When I returned to Columbia, I confronted an office crisis. For the first time in my career, I faced controversy and angry criticism prompted, I believe, by my VA superior, Dr. Bauer, in retaliation for my whistleblowing. By the end of the summer, Dr. Bauer charged me with poor administration of research funds, mismanagement of the equipment inventory, and unprofessional and disruptive behavior. On August 19, 1996, he asked the hospital director, Mr. Campbell, to relieve me of my duties. Instead, Mr. Campbell arranged for the VA to appoint a panel to review my performance.

Even though I knew Dr. Bauer's charges were bogus, I believed it would be pointless to fight the VA, so I asked Dr. Bauer if we could negotiate my resignation from the VA. Dr. Bauer refused. My attorney repeated this offer to Mr. Campbell and to Dr. Kizer, but they also refused. For this reason, I am convinced the VA intended to destroy the credibility of my accusations by destroying my professional credibility and with it, my career.

On November 6 and 7, 1996, a VA panel convened a kangaroo court to review my performance. They did not follow due process. I was not allowed advice of counsel. There was no record of the proceedings. I was not allowed to hear or rebut the testimony against me. Nevertheless, after hearing my side of the matter, the panel agreed that the evidence did not support the charges.

I thought that ended the matter, but 8 months later, I received an unsigned, undated copy of the panel report which recommended my removal. The next day Dr. Bauer rated me unsatisfactory on my 1996 performance appraisal, setting the stage for my forced removal. With the help of legal counsel and, I suspect, Members of Congress, the demotion did not proceed. Instead, Dr. Bauer left the VA.

Following the departure of Dr. Bauer, I calmed the Research Service and reestablished our tradition of efficient service. Throughout the ordeal, I kept our expenditures under budget while maintaining full administrative services. In 1997 and 1998, we were one of the few Research Services in the VA system to demonstrate an increase in research funding. In 1998, we set aside $70,000 from operating funds for the recruitment of a new physician investigator to the hospital.

But I continued to work in a hostile environment. I had to give up my position as Chief of Infectious Diseases. I am excluded from committee appointments and high level planning. Senior management and Dr. Bryant, the dean of the medical school, have publicly complained on numerous occasions that the bad publicity caused by my actions could close the hospital and cause people to lose their jobs.

The reprisals escalated in the weeks surrounding the Havrum trial, which was held between July 27 and August 8. On July 10, while vacationing in Canada, I learned without explanation or warning that Mr. Campbell, the Hospital Director, had vetoed my appointment to the VA Disciplinary Appeals Board and canceled training I was scheduled to receive in Denver.

When I returned to Columbia, I learned that Dr. Adelstein would have to face a Board of Investigation over an incident involving the

drug Sleepaway that had taken place in the Research Service in December 1996, nearly 2 years before.

I was not personally concerned because the matter did not seem to involve me. I had filed a full report with Dr. Bauer in August of 1997, a year earlier, and his staff assistant had told me that everything was fine. It seemed to me that resurfacing the issue just before the Havrum trial was an attempt to intimidate Dr. Adelstein.

I did not know it at the time, but on August 20, the hospital reported to the Drug Enforcement Agency the Sleepaway incident and Dr. Adelstein. The hospital claimed this incident had just come to their attention. Naming me by name, the hospital said I had failed to report this incident to them. This was a lie. The hospital knew about this incident 11 months earlier, when I had reported it to Dr. Bauer.

On July 22, Mrs. Patricia Crosetti, the VISN director, appointed a Board of Investigation for the Sleepaway incident and, on September 1, 1998, she expanded the scope of the Board Investigation to include a review of my performance.

Once again, the Board did not follow due process. The Board did not warn me that I had been made a target of this investigation. I did not have advice of counsel. I was not allowed to submit evidence in my favor. In the end, Board recommended that I receive written and oral counselling.

During the same time, Mrs. Crosetti's office began planning a proposal to eliminate my position and combine our Research Service with the St. Louis Research Service. The proposal, however, encountered heavy criticism, and I suspect it has been withdrawn.

It is impossible to fight a 6-year campaign with the Federal Government and maintain high level professional productivity, but I have enjoyed success. I continue to publish research articles and I have obtained a merit review research grant. I regularly receive top scores for my teaching. My physician colleagues selected me to be added to the list of best doctors, and my university colleagues elected me to the faculty senate.

This ordeal has taken a personal toll. I have spent more than $50,000 defending myself. The conflict has hurt my daughters and my wife. It has also hurt my friends and co-workers. Some have become targets simply because they are associated with me, others, like Dr. Andrew Simpson, have become targets because they helped me fight this issue.

Perhaps the VA thought they could hound me out of the practice of medicine, but I will not leave. I will finish this. I insist that the VA cease behaving like a public monarchy ruled by little emperors and queens. I insist the VA start conducting its business like a public service, according to public law, staffed by public servants who put loyalty to the highest moral principles and to country above loyalty to the Department of Veterans Affairs.

Thank you very much, Chairman Everett, for your support.

[The prepared statement of Dr. Christensen appears on p. 90.]

Mr. EVERETT. Thank you, and I want to thank all of you for agreeing to appear here today. I know when each of you started down the course of becoming whistleblowers, you never thought you would be before a congressional committee under sworn testi-

mony. You did it because you thought it was the right thing to do and that right people do right things. It has been my disappointment to find out that that does not necessarily happen.

You are private citizens who happen to be or have been VA employees and you spoke up. Your lives are changed forever by your actions and the actions those in authority taken against you. All of you have suffered greatly because of what you did, because you did what you thought was right.

As chairman of this subcommittee, I thought each of you should have the opportunity if you desire to be heard in public about your experience as a whistleblower.

The five whistleblowers from Columbia, MO and Alabama have been recognized, perhaps belatedly, as whistleblowers by the VA. In fact, all five have been providing a considerable amount of information to the committee and subcommittee.

Ms. Pastor, a former medical research employee of the Philadelphia VA Medical Center, is in a different situation and is still seeking an official acknowledgment that she is a whistleblower. She was invited here today because the subcommittee could corroborate certain parts of her allegations significantly enough to believe that they raise legitimate issues. Of course, her testimony was under oath, along with everybody else's.

This has been powerful testimony. Before the witnesses were whistleblowers, they prospered, their careers flourished. I find it very ironic that every single one of you had outstanding performance records up until the day you became whistleblowers and completely a 180 degree change from that point on. That alone is an indictment against the VA system. That can be read no other way than as a singular indictment against the culture that exists in the VA, retaliation and abuse of position and authority that we have just heard about and the wreckage that it causes. It cannot and should not be tolerated by the VA any longer.

Those are old words. I have had the privilege of meeting with some of you before. I want to tell you it is hard to turn this train around.

There is a culture that exists within the VA, it is very deep-rooted and you are right, these hospital directors think that is their little kingdom and they are going to run it just like they want to run it.

I had a disabled veteran in my office, a double amputee sitting in a wheelchair, who had a run-in with a hospital director. He told the hospital, "Well, I'm going to write my Congressman."

The hospital director looked at him and said, "I don't give a damn what you write. I've been doing this for 20 years and I'm going to run this hospital the way I want to run it."

That, too, is an indictment against the culture that exists within the VA.

Dr. Adelstein, the board of investigation over the dog incident, I mean, that is Keystone Cops. That is so stupid and ridiculous that it infuriates me that it even happened. Whoever initiated that action really ought to be removed. I mean, it is just plain stupid.

You were right, Dr. Christensen, you mentioned a kangaroo court. It seemed to me that they are prevalent within the VA. I see cases of it over and over and over and this subcommittee is really

getting tired of the situation that exists in Columbia, MO, and I will have more words about that later.

First of all, let me ask you to be very brief because we do have another subcommittee hearing, a full committee hearing, that will follow this immediately in this same room. Very briefly, can each of you tell me where you were retaliated against, at what point in your career and what for?

Mr. Wilson, I am sorry, we will start with you.

Mr. WILSON. It began with the consolidation of Montgomery and Tuskegee, and that was in 1997.

Mr. EVERETT. Mr. Bumgardner, the same?

Mr. BUMGARDNER. Yes, sir. I have May of 1997, when I met with you in Montgomery in the mayor's office, basically it started then.

Mr. EVERETT. Dr. Adelstein?

Dr. ADELSTEIN. It seriously occurred in 1992, when I was responsible for partially disclosing about the deaths and the cover-up.

Mr. EVERETT. In 1982?

Dr. ADELSTEIN. 1992.

Mr. EVERETT. 1992. Continue.

Dr. Dick?

Dr. DICK. It also for me was in 1992, when it began, and it has continued until the present time.

Mr. EVERETT. Dr. Christensen?

Dr. CHRISTENSEN. Again, September 2, 1992, when I would not be a team player and participate in the cover-up of the deaths.

Mr. EVERETT. Ms. Pastor?

Ms. PASTOR. August of 1996 through May of 1998.

Mr. EVERETT. What has the VA done—can any of you name anything the VA has done to protect you, particularly those of you who are the five recognized whistleblowers?

Dr. DICK. No.

Dr. CHRISTENSEN. There have been no lessons learned by the VA. If the same thing occurred today, I have every reason to believe the same events would take place again.

I believe we do have a system that promotes people to high positions who have demonstrated a lack of integrity and honesty. If they get to a high level, these people allow the system to make these mistakes.

Dr. ADELSTEIN. I found no protection whatsoever. As I said, I have a local grievance and an Office of Special Counsel investigation that is current, but going through the local process has been very futile so far.

Mr. EVERETT. Mr. Wilson?

Mr. WILSON. No, sir. None whatsoever.

Mr. EVERETT. Do any of you know what has happened to the people that did the injustice to you?

Dr. DICK. Mr. Kurzejeski retired. In the year of the deaths, I believe, he received his first bonus from the VA, and I believe that was a $20,000 bonus. And he also received a bonus upon retirement. Mr. Campbell, who is the current director, I believe is receiving bonuses at this time.

Ms. PASTOR. Dr. Dunkman has continued to work at the Philadelphia VA and he, to my knowledge, has not had any problems from all of the wrongdoing.

Mr. EVERETT. Continues to work? Now, this is the gentleman that gathered up old medicine, repackaged it, and distributed it to patients?

Ms. PASTOR. Yes.

Mr. EVERETT. Well, that is really——

Ms. PASTOR. And caught.

Mr. EVERETT. That is real reassuring that he is still working. That really is.

Mr. BUMGARDNER. Mr. Clay and Mr. Hawkins have been detailed, but also the selection for the administrative service chiefs, we were told it would have to be approved by Mr. Deal and Mr. Deal is still a VISN director and I understand received, I believe, a presidential rank award.

Dr. ADELSTEIN. From my impression, the people in charge of the quality assurance program are still in place, as well as the public relations people who worked very hard with the director to maintain the cover-up.

They still maintain their positions, having had numerous promotions and advancements within the system. The dean of the university school of medicine, when he was actively taking action against Dr. Christensen and Dr. Dick, became a member of the prestigious senior management advisory committee in the VA, and I felt all those were directly resultant to his actions in suppressing the murders.

Mr. EVERETT. Thank you. Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman.

I want to thank each of you for what you have done. Knowing that you were risking your jobs, you reported serious situations ranging from mismanagement to unnatural patient deaths. You are whistleblowers and you have faced retaliations.

We have read your testimony and we share your sense of outrage. I want to thank each of you for your courage and your integrity.

For the whistleblowers, VA points out that none of you have received disciplinary action. Can you respond to that?

Dr. CHRISTENSEN. We have each received a series of criticisms, some in writing, which formed the foundation for a job action. Your point is correct, that none of us have been fired at this point, but we feel that the knife is imminently over our head.

Ms. BROWN. What about loss of pay or pay grades? Or does someone else want to respond to that?

Dr. DICK. The VA has lowered proficiencies, it has reassigned duties, it has removed employees from supervision, it has changed my supervisor to someone else.

I lost some $20,000 a year of income from the time that I left the chief of staff position, so that is over 4 years ago. I also, as Dr. Christensen, have had legal expenses trying to defend myself. The out-of-pocket costs have exceeded $65,000. There are still unpaid bills.

Dr. Simpson, who also worked with us on this, told me that he has lost salary of some $52,000 to $54,000 over the period of time.

Dr. ADELSTEIN. In general, my threats have been mostly to destroy my career by firing a silver bullet in my heart, which missed, regarding the allegation of theft of a drug and just because they

missed does not mean that it is not serious and it is even more serious because as a witness, both as a VA employee and as a deputy medical examiner, I believe that is a serious violation of a public official's responsibilities and I think it should be taken very seriously. I believe that is a criminal offense.

Mr. BUMGARDNER. While I did not lose pay, I have incurred close to $10,000 in legal expenses so far. I think the most tragic thing is the loss of health that I have incurred. The stress that I underwent and the stress that I go under now rehashing those things that took place against me.

Mr. WILSON. No, ma'am. I chose to leave the situation and find myself another job somewhere else.

Ms. BROWN. Once again, I want to thank each of you for your whistleblowing.

Mr. EVERETT. Again, I would also like to thank you and while I find your testimony very credible and heartrending and scary in some cases, obviously, it shows the power that can be brought down on an individual by officials of this government, and that power should have controls on it. And I do not see those controls being exercised properly.

Dr. Adelstein, not to disagree with you, but let me just simply point out that I have been here doing this job or other committee chairmanships for 7 years and I am familiar with Dr. Kizer and the things he says and does, and I do not believe the statement he made that your job is not secure was made in the context of whistleblowing.

Dr. ADELSTEIN. No, it was not. It was a general statement made when he came to take over the organization.

Mr. EVERETT. The reorganization of the VA system.

Dr. ADELSTEIN. That is exactly correct, but I saw it as not a friendly statement for working well together.

Mr. EVERETT. Thank you very much. And I again want to thank this panel for appearing here today and also for the courageous steps that you have taken, not only to protect our nation's veterans, but also the nation's taxpayers.

What you have done is good for the nation and I am sorry, I am truly sorry, that you have been put in the position that you have been put by your government.

Thank you very much.

I recognize Mr. Eugene Brickhouse, Assistant Secretary for Human Resources and Administration, and Ms. Leigh Bradley, General Counsel, and have them introduce the rest of their panel, please.

Let me welcome you and ask that you all please rise.

[Witnesses sworn.]

Mr. EVERETT. Let me start off by saying—with a little gripe, if you do not mind.

As the VA knows, I sent two letters to the department about whistleblower retaliation—one letter is dated September 8, 1998 and the other letter was a follow-up update November 23, 1998—asking where the answer to the first letter was. Maybe it was too subtle.

The department's answer finally came on February 24, 1999, despite several inquiries at my direction by my subcommittee staff as to the reply's status.

I ask unanimous consent that the letters and the reply be made a part of the record. The department's reply will be redacted.

(The letter follows:)

DEPARTMENT OF VETERANS AFFAIRS
PRINCIPAL DEPUTY ASSISTANT SECRETARY
FOR CONGRESSIONAL AFFAIRS
WASHINGTON DC 20420

February 24, 1999

The Honorable Terry Everett
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your request for information concerning employee personnel histories from the VA Hospital (VAH) Columbia, Missouri, VA's policies on whistleblowers, and the scheduling of a briefing for you on the above subjects. This letter has been referred to me for reply. I would also like to acknowledge your follow-up letter of November 23, 1998, requesting additional information on the number of cases in which VA employees have claimed whistleblower status and a summarization of each case for the past ten years. This additional information will take some time to gather, as it must come from several different offices, both internal and external to VA.

In accordance with your oversight request, the enclosed information is provided to you in your capacity as Chairman of the Subcommittee on Oversight and Investigations of the House Committee on Veterans' Affairs. The enclosures contain information which is covered by the Privacy Act, 5 U.S.C. § 552a.

The current Hospital Director, Mr. Gary Campbell, has made every attempt to acknowledge the events that occurred in 1992 and more importantly, to move forward in addressing corrective actions and improving conditions at the hospital. From the time of his arrival in April 1996, Mr. Campbell has continually focused on assuring that appropriate corrective actions were taken, appropriate monitoring systems were in place and maintained, and that the medical center moved forward with the overall transformation of VA healthcare. For example, he directed the hospital to send an alert letter to the Missouri State Licensing Board about the nurse in question for the 1992 events in accordance with revised Veterans Health Administration (VHA) policy. He has ensured that national VHA policies on quality improvement, sentinel event reporting and other clinical guidelines have been implemented and maintained at the facility. He has ensured that discussion of these policies and procedures, as well as corrective actions taken by the facility, have been fully discussed in appropriate clinical

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forums such as the Clinical Executive Board, meetings of the entire medical staff and Director's Staff meetings. The specific corrective actions included: (1) 100 percent review of all deaths, with any "unexpected" deaths forwarded for internal peer review; (2) trended data on deaths and codes maintained and reported on a monthly basis by ward and treating service; and (3) establishment of the Hospital Peer Review Board. In addition, these subjects have been thoroughly and repeatedly discussed at several all-employee "town hall" meetings and regular and ad hoc meetings with representatives of veterans' service organizations. They were reiterated at press conferences that were conducted at the conclusion of the following events: the 1996 VA Medical Inspector's review; the February 1998 release of the FBI's Report of Investigation; and the August 1998 civil lawsuit judgment.

Patient safety has been repeatedly emphasized in meetings with the clinical staff of the hospital with requests for suggestions and ideas. To date, the hospital has submitted two nominations for the Under Secretary for Health's National Patient Safety Award. This award is designed to increase the emphasis on identifying adverse events or potential patient safety situations and to improve processes or practices that minimize or eliminate the risk of an untoward, clinical outcome. Another example of the Director's attempt to move the hospital forward followed the August 1998 civil trial against the government. He met with two of the employees identified in your letter (Drs. Christensen and Adelstein) and requested their suggestions and ideas about patient safety and how the facility could move forward.

The Risk Management Policy for VHA has been modified several times since the 1992 deaths at VAH Columbia. The most significant change occurred this year with the complete revision and publication of VHA Directive and Handbook 1051, Patient Safety Improvement, dated January 13, 1998. The major change of this directive and handbook is the establishment of a statistical consultant(s) who is/are available to assist in data analyses for patient safety, quality assessment and performance improvement for their respective Veterans Integrated Service Network (VISN).

With respect to your concerns about the appearance of a continuing pattern of intense scrutiny, selective performance and disciplinary reviews, and disparate treatment of certain VA employees, the information you requested follows. In addition, we thought it would be helpful for you to know that previous

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allegations from the Associate Chief of Staff for Research and Development (ACOS/R&D), Dr. Christensen, were addressed through a September 1996 review. This review of reprisal allegations was conducted by Guy H. McMichael III, VA Dispute Resolution Specialist, at the request of the Under Secretary for Health following an October 1995 hearing of the House Veterans Affairs' Subcommittee on Hospitals and Health Care. As a result of that review, a Research Site Visit, chartered by the Chief Research and Development Officer, was conducted at the facility. Recommendations from that review included the removal of Dr. Christensen from his position as ACOS/R&D.

[redacted] The full site visit report is included in Enclosure 1.

As requested, personnel histories for Gordon D. Christensen, M.D.; Edward H. Adelstein, D.V.M., M.D.; Earl P. Dick, M.D.; and Walts A. Simpson, Jr., Ph.D., are provided as Enclosure 2. Enclosure 3 is a summary of the significant points of the Whistleblower Protection Act and outlines whistleblower protections for VA employees.

Drs. Christensen, Dick and Adelstein cooperated with the OIG by providing information during the OIG's investigation of issues surrounding the suspicious deaths at VAH Columbia. Such activity is protected and they are, thus, afforded protection under law against reprisal for these activities. Dr. Christensen also asserts that he made disclosures to the OIG of information evidencing a violation of law. Retaliation on the basis of a qualifying disclosure, such as a violation of law, is also prohibited.

VA has issued the following documents concerning protections for whistleblowers:

When the Whistleblower Protection Act of 1989 was enacted, VA issued a Personnel Circular Letter to all Human Resource Management Officers containing guidance on the Act and informed them that all managers should be made aware of the provisions;

- VA distributed copies of the Merit Systems Protection Board pamphlet, "Questions and Answers About Whistleblower Appeals," on at least two occasions to Human Resources Management offices in VA field facilities;

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- In 1993, the Secretary issued an all-employee letter underscoring his determination that VA employees should feel free to raise their employment-related concerns without fear of retaliation or reprisal and implemented a requirement for higher-level review of investigative reports of complaints of reprisal;

- VA policies regarding disciplinary and adverse actions contain tables of recommended penalty ranges for various infractions. The penalties for committing a prohibited personnel practice, or for reprisal against an employee for filing a complaint under established procedures, range from reprimand to removal for the first offense. The range of penalties for reprisal for providing information to the Office of Inspector General (or equivalent), the Office of Special Counsel, or to an EEO investigator, or for testifying in an official proceeding is a ten-day suspension to removal for the first offense.

In addition to the above actions, the OIG strives to ensure that all Department of Veterans Affairs' employees are cognizant of their right to disclose fraud, waste, and abuse to the Inspector General and that they have ready access to the Inspector General's staff. To receive employees' disclosures, the OIG Hotline operates a toll-free telephone service, offers a Homepage on the Internet, and is accessible by e-mail and the U.S. mail. Previously, OIG staff distributed posters and business cards to all VA facilities informing employees how to contact them and ensured that major VA facilities included the OIG's telephone number in their directories and in major city telephone book directories.

When the OIG receives an allegation of whistleblower reprisal from an employee, staff inform the complainant of their right to file a complaint with the Office of Special Counsel (OSC). The OSC is responsible for investigating allegations of whistleblower reprisal and is authorized by statute to enforce remedies, such as stays, corrective actions, and disciplinary actions relating to cases it reviews. OIG encourages complainants to seek these greater protections available through the OSC. However, the OIG may consider reviewing a whistleblower reprisal case at the request of Congress, the Secretary's Office, or when the employee requesting assistance made the protected disclosure to the OIG and/or does not wish to seek OSC's assistance. The decision for the OIG to conduct such an administrative review is made on a case-by-case basis.

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Appropriate officials within the Department have carefully reviewed the issues you have raised. VA is committed to ensuring that employees and managers understand their rights and responsibilities regarding the protection of whistleblowers. As a result, VA will be taking the following actions:

- We will provide written guidance to executives and managers regarding the protection of whistleblowers and their responsibilities to ensure that employees feel free to report their concerns without fear of reprisal. In this regard, we have already begun the dialogue with Headquarters' officials, VISN Directors and others regarding the types of activities that are protected;

- We will provide information on the whistleblower protections in new employee orientation and supervisory training;

- We will issue an all-employee letter providing information on whistleblower protections.

We look forward to meeting with your staff in the near future to discuss these issues more in depth. Thank you for your interest in this and other matters affecting our Nation's veterans and the staff that serve them.

Sincerely,

Sheila Clarke McCready

Shella Clarke McCready

Enclosures

Mr. EVERETT. I want to know why it took the VA more than 5 months to answer my letter. I hate to think what kind of responsiveness this means to our veterans when an oversight subcommittee chairman cannot get an answer to an official inquiry on an important matter.

The VA has a system at Central Office called EDMS for tracking correspondence, and I want to know who at the department had the reply to my letter and for how long.

Finally, I want to know what the VA is going to do ensure that this does not happen to not only this subcommittee chairman, but any subcommittee chairman again.

If any member of the panel would like to respond to that, I would be happy to get a response.

Mr. BRICKHOUSE. Sir, I would like to submit to you that the VA apologizes and has no excuse for not answering those letters in a timely way. We have had some discussions about how we answer correspondence and I think you will see some steps taken to not allow that to happen again.

I will gladly provide for the record the answers to your two specific questions, who and how long, and what we are going to do to correct the problem for the record.

Mr. EVERETT. I appreciate that. You may now proceed with your testimony.

TESTIMONIES OF EUGENE A. BRICKHOUSE, ASSISTANT SECRETARY FOR HUMAN RESOURCES AND ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; AND LEIGH BRADLEY, GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY KENNETH CLARK, CHIEF NETWORK OFFICER, VETERANS HEALTH ADMINISTRATION; RONALD E. COWLES, DEPUTY ASSISTANT SECRETARY FOR HUMAN RESOURCES MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; AND WALT HALL, ASSISTANT GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS

TESTIMONY OF EUGENE A. BRICKHOUSE

Mr. BRICKHOUSE. Good afternoon, Mr. Chairman, and distinguished members of the committee.

We thank you for the opportunity to appear before you and share information on protections offered and afforded to our VA employees who believe they may be subject to retaliation for disclosures or complaints. As you can appreciate, this is a complex matter that crosses organizational lines within VA.

With your permission, I will introduce my colleagues at the table and very briefly summarize the department's formal testimony. Then the General Counsel would like to offer brief comments. We understand that the full written statement will be submitted for the record.

Mr. EVERETT. Absolutely.

Mr. BRICKHOUSE. And, of course, we will be pleased to respond to any question that you may have.

Seated with me at the table is Mrs. Leigh Bradley, VA General Counsel. To my left, Ken Clark, Chief Network Officer, Veterans Health Administration; Mr. Ron Cowles, Deputy Assistant Sec-

retary for Human Resources Management; and Walt Hall, Assistant General Counsel.

And might I add that we are also accompanied by Mr. Chuck Delobe. He is Director of the new Office of Employment Discrimination Complaints Adjudication. Also Mrs. Ventris Gibson, Deputy Assistant Secretary for Resolution Management; and John Klein, Assistant General Counsel.

Mr. Chairman and members of the committee, there are a number of avenues for VA employees, indeed for all federal employees, to pursue if they feel they have been retaliated against because of whistleblowing or other complaint activities. These are outlined in our testimony.

More importantly, we understand that the committee wants to know how effectively VA communicates this information to employees and how aggressively we ensure compliance with those protections. VA fully supports the protection of whistleblowers and will not condone reprisal against them.

At the same time, we recognize that there are steps that we can take and, in fact, we have already initiated many of them, to improve our management of whistleblower protection matters. These include centralized information collection to ensure more effective program management; emphatic, consistent and renewed guidance on rights and responsibility of the employees and managers; and strict accountability, including discipline as appropriate when violations take place.

It is critical that employees have a sense of trust in the protections that they are afforded and that they feel they can exercise their rights and their responsibilities without fear of reprisal. VA is committed to developing a workforce that understands this and takes it seriously.

Mr. Chairman, in concluding, I want to again apologize on behalf of the department for the failure to respond in a timely manner to your letter of September 8, 1998. This delay, in my opinion, was inexcusable and it will not happen again.

Your follow-up letter dated November 23, 1998 has been referred to my office and we are coordinating with your staff and with other VA offices to develop the information that you have requested.

At this point, I would like to turn to Mrs. Bradley, VA general counsel, who is going to say a few words on behalf of the Secretary.

Thank you very much.

[The prepared statement of the Department of Veterans Affairs appears on p. 95.]

Mr. EVERETT. Without objection, Ms. Bradley.

TESTIMONY OF LEIGH BRADLEY

Ms. BRADLEY. Thank you. Mr. Chairman, Congresswoman Brown, I would like to take just a moment to emphasize some of the things that Assistant Secretary Gene Brickhouse has said.

VA is serious about doing what is necessary to improve its efforts in all aspects of whistleblower protection. Secretary West has expressed to me personally and asked that I convey to you this morning his determination to identify what needs to be done. He is committed to seeing to it that those things are done and done without undue delay.

The Secretary has personally informed senior VA management that Assistant Secretary Brickhouse and I have been tasked by him with overseeing this VA effort. We are to keep him closely informed and we will do so. Toward this end, a task force has been established at the Secretary's request to take a hard look at VA's policies, practices and experience in this area.

The task force is now drafting its charter. One of its charges will be to identify the information needed for proper management of whistleblower protection matters, including the establishment and maintenance of a centralized repository of information pertaining to all reprisal or whistleblower cases arising within our department.

Our expectation is that the work of this team will lead us to new initiatives which VA can implement to better encourage whistleblowers to come forward, to better prevent retaliatory actions against them when they do so, and to better respond to such retaliation when it is found to have occurred.

This will not be an easy task, but it is vitally important that we underscore our commitment to this and related efforts in order to assure that our department has done all that it can to encourage the disclosure of illegality, waste and corruption and to protect those who uncover it.

We appreciate this committee's focus on these issues and we value the support and perspective its members and staff can offer us as we proceed.

Thank you, Mr. Chairman, and at this time we are prepared to respond to your questions.

Mr. EVERETT. Thank you very much.

Dealing with whistleblowing and retaliation situations is sometimes very difficult, and I appreciate that. As I said in my letter, reprisal can be as subtle as it is ugly and whistleblowing does not make employees immune from legitimate performance and disciplinary reviews.

But having said that, the VA's February 24 response is remarkably similar to what the committee heard from the VA after the sexual harassment cases in Atlanta VA medical center in 1993.

I know your intentions are good, but this committee sat here and heard the very same thing in that situation, much sound and fury about zero tolerance of sexual harassment and very little in the way of real change because 4 years later almost the same thing happened again somewhere else. As a matter of fact, there are probably several—there were over a dozen cases that happened.

This bipartisan subcommittee had to take it away from the VA and drive the change by statute, an amendment that I wrote that was passed by the Congress.

You are going to have to convince me this time that VA can effectively change on its own. I do not hesitate in saying it will not matter in the future years if Terry Everett is sitting in this chair or Ms. Brown is sitting in this chair, we intend to protect VA whistleblowers.

You have heard the testimony of six current or former VA employees. The government accountability project has summarized the tactics of retaliation most often used against whistleblowers. I

ask the VA if they heard evidence of any of the following reprisal activities:

Did the VA make the whistleblower instead of his or her message the issue?

Did the VA try to brand the whistleblower a chronic bad employee? It is remarkable—it is remarkable that every single one of the people sitting at that table that preceded you had outstanding performance records over and over and over again until the day they became whistleblowers. At that point, their performance records went down the tube.

Did the VA ever threaten them into silence?

Did the VA isolate or humiliate them?

Did the VA set them up for failure?

Did the VA persecute them?

Did the VA try to eliminate their jobs or perilize their careers?

Anyone may answer.

Ms. BRADLEY. Mr. Chairman, let me start off our response and tell you that I share your concerns. We need to underscore a commitment to ensure that we take appropriate corrective action when we find out that someone has in fact been reprised against for making protected disclosures.

I think that each one of the cases that was presented today at the witness table is a different one and, as you know, we could talk about each individual case and what we intend to do with respect to each individual case.

But before we get into specific cases, I just want to be clear on the record that part of Secretary West's commitment and the commitment of Assistant Secretary Brickhouse and myself is that we want to not just look at discipline that is taken against the wrongdoer, but to renew our focus on making whole those courageous people who come forward. And I assure you we will do that.

Mr. EVERETT. I certainly appreciate that and also, by the way, congratulations on joining the team, and I like to know that a fellow Alabamian is involved.

But I hope you will understand that much of what has been said by you today has been told to his committee in other cases, for instance, the sexual harassment case, and there simply was no follow-through.

The thing that concerns me that there is without question a good old boy network within the VA. That is without question. And we can give you example after example, there is no need to, of where higher ups have been given no discipline whatsoever for the actions they have taken.

We have one director that was transferred after sexually harassing, physically or verbally, five women who under oath sat at that table and testified, the man was transferred to Florida, where he already had a retirement home.

Now, what kind of punishment is that? It is no punishment. It was only at this subcommittee because the VA had signed a document saying that they would not prosecute, bring any charges against that director, to get him to leave his position. The guy ought to be fired. Period. He is unfit to serve within the VA or any government agency. Yet he was given a pass, he was allowed to go

to where he already owned a vacation home and, by the way, got a raise out of it, I think a $85,000 relocation fee.

These are the kind of things that we see over and over again and you will hear me say this a lot, but the culture within the VA has simply got to change or the VA will no longer be able to exist. It cannot exist under this present culture. It just simply cannot do it.

The cases that I read off to you, I am simply saying these are the ways that retaliation takes place and these are—some of them are ugly and some of them are subtle and this is what you are going to have to look forward to solving.

Ms. BRADLEY. May I respond?

Mr. EVERETT. Certainly.

Ms. BRADLEY. Chairman Everett, as you know, I was sworn in in October of last year and I can assure you that the case that you are talking about has been briefed to me and mentioned, I would guess, at least once a week.

I know it is not a large step forward, but I can assure you that there were some significant lessons learned from that case and some significant changes in the way we review disciplinary matters based on our actions or lack thereof in the case to which you were referring.

Now, one of the measures that I am speaking of is something that I guess I would term an enhanced review mechanism. I believe that you are aware, but let me also make clear for the record that now in the case of any senior official who is proposed for some disciplinary action, the matter is not simply reviewed out in the field.

Those senior officials' proposed actions must come forward to the Central Office where now my office is involved and in fact I am personally involved. Those actions are also reviewed in the Office of Human Resources Management by Gene Brickhouse and his staff and ultimately may go to the Deputy Secretary of Veterans Affairs and the Secretary of Veterans Affairs.

So that is also another way to provide a second layer, if you will, of review and accountability because as we all in this room know, accountability is what is critical if whistleblowers in the future are to feel that they can come forward and that management will support them.

Mr. EVERETT. Thank you very much. Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman.

What does the VA intend to do to give its employees confidence that they can go up the chain and report incidents of mismanagement, fraud or other crimes or breach of patient safety without fear of reprisal?

Mr. BRICKHOUSE. Congresswoman Brown, I think that we have already identified and initiated many matters to deal with that.

For example, as Chairman Everett mentioned, there was a law passed dealing with how we handled EEO cases within the VA last fall. I think VA's implementations of that legislation, forming two organizations to deal with these matters differently, is already paying a great benefit to the employees.

On the whistleblowing matter, as Mrs. Bradley has already mentioned, we did not wait to come down here and be a part of this hearing today. We have already initiated and set up a review team to find better ways of dealing with these matters.

As another example, Ms. Kaplan this morning said from OSC that she wanted to establish a liaison. We have already talked to her and we will do those kind of things.

So in summary, I think in calendar year 1997 and 1998 we embarked on many areas to deal better with EEO, especially sexual harassment, and we are going to deal with whistleblowing in the same manner.

Ms. BROWN. In reviewing some of these cases, the length of time that it takes to resolve these cases, why is it that it takes so long?

Mr. BRICKHOUSE. I am going to ask my colleagues here at the table to help me with this particular question.

Ms. BRADLEY. I think that our experience proves that particularly in some of the more contentious whistleblower cases you have layers upon layers of witnesses that have to be interviewed.

For example, in the Central Alabama case, there were over 100 allegations that were brought forward to the attention of the IG. He began his investigation, I believe, in June of 1997.

Nearing the end of 1997, additional allegations, this time about employee reprisal, were brought to his attention and so he had to follow up on those. There were, I believe, six witnesses that were interviewed pursuant to those allegations.

We received the first draft of the IG report in the Central Alabama case in March of 1998. Additional site visits were made by the Veterans Health Administration and then finally after all of the evidence was amassed there were a series of meetings because there were some differences of opinion as to how to interpret the evidence and how to take appropriate action.

So I have to tell you that while I do apologize for the length of the process and I feel bad because, as I believe Chairman Everett said, what happens is this leaves whistleblowers and the entire organization hanging in the wind. However, we also have to make sure that we are very thorough and exhaustive in our reviews, that we are fair to people in terms of their rights under the law, and we at Central Office need to feel confident that the actions that are being proposed at a lower level are in fact appropriate.

So we can work hard on trying to make the process more efficient, but I do not want to lead you to believe that we can make significant strides in that respect because the process is going to take a considerable amount of time, particularly in these whistleblowing cases.

Ms. BROWN. Many of the whistleblowing cases we have examined seem to bear out the suggestion made by the Office of Special Counsel that attention is needed to be given to personnel training, particularly for directors who have purely medical backgrounds. I assume when they were in college they did have some human skills training, but what is the department planning on doing?

Mr. BRICKHOUSE. Congresswoman Brown, we have been conducting training. I have to admit to you, though, it has been completely decentralized and as we have reviewed it, we have found that the training at the decentralized level is inconsistent and so what we think we need to do and part of the task force's charter is to find a better way of conducting more training, that is one thing we are going to do, and also we will find a way of doing it more consistently across the VA in its entirety.

So in summary, we are doing training but it is not consistent across the board. As you know, we are a very large activity, 500 facilities located around the country, but, again, I can commit to you that this review team will look at it and we will do some of those things differently.

For example, another thing that we do on an annual basis, is require ethics training for all of our employees. Why not add training on whistleblower protections to it? And that has been discussed.

Ms. BROWN. Lastly, what can we in Congress do to assist you in doing your job better?

Mr. BRICKHOUSE. Let us go back to the public law that was passed back in 1997. I do want you to know that we worked very closely with your staffs on effecting and implementing that. Your professional staffers came out and looked at our training and reviewed our programs as we were effecting and implementing that new law and I think we have done a good job of that.

I think we do not need a new law to deal with whistleblowing, in my opinion, as we had for EEO. I think we are going to take some initiatives on our own. I think we can closely keep you and your staffs advised of what we are doing and let you be a part of it and let you help guide us through this.

Ms. BROWN. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you.

Let me make a few closing comments and then a closing statement.

First of all, I would like to ask you to please report to the subcommittee in 60 days on the action the VA has taken with respect to the matters raised at these hearings, and I make specific reference to the six people on the panel, any action or the lack of action taken in cases involving them or anything you get involving them. And I include lack of action.

I would like to comment on fact the VA physician researcher in Philadelphia collected old and sometimes expired medications from patients, rebottled them, and gave them to other patients at the hospital.

I must say that whatever the doctor's motivation was, this is one of the most bizarre episodes in a VA hospital I have ever heard of. I would think that the person who exposed this would almost have to be considered a whistleblower. In that respect, I would ask you to take another look at Ms. Pastor's allegations and what has happened to her since her case. And I repeat, that is very bizarre and I find it disturbing, frankly, that that doctor is still practicing at that facility.

The subcommittee has asked the VA to provide a copy of the Philadelphia VA Medical Center memorandum dated June 9, 1997 regarding Joan Pastor, and it was provided. That is correct, I believe. And I ask unanimous consent that it be made part of the record.

This memo appears to list several protected activities, such as filing complaints, as a basis of wanting to move Ms. Pastor out of her assignment or to terminate her. The memo could be subject to several interpretations, but I would have to think that this is a strong case in Ms. Pastor's favor.

(The information follows:)

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

March 9, 1999

MEMORANDUM FOR ADMINISTRATION HEADS, ASSISTANT SECRETARIES AND OTHER KEY OFFICIALS

RE: WHISTLEBLOWER PROTECTION

Several years ago, the Department required that all investigative reports of complaints of reprisal be reviewed by senior managers in order to determine whether or not their personal intervention is required and to ensure that appropriate action is taken when individuals are found guilty of reprisal. This requirement remains in effect except for complaints filed under the equal employment opportunity (EEO) procedure. Allegations of reprisal in discrimination complaints, like EEO complaints themselves, should be brought to the attention of a VA Office of Resolution Management counselor. These requirements are intended to send a strong, clear message that reprisal is a serious matter and that we all share the responsibility to ensure that our employees are protected and feel free to come forward with their concerns.

Let me remind you: reprisal against employees for whistleblowing activities will not be tolerated. Please take this opportunity to reinforce the awareness of your supervisors and managers concerning their responsibilities. To help ensure that employees understand this Department's commitment and their rights, I am issuing an All Employee Memorandum (attached). The memorandum emphasizes specific protections in law that prohibit reprisal against employees for whistleblowing (5 U.S.C. 2302(b)(8)), and describes how they may seek redress if they believe they have been subjected to a personnel action because of whistleblowing.

In addition, I direct that information about whistleblower protections and responsibilities be included in new employee orientation programs and supervisory training.

Togo D. West, Jr.

Attachment

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

March 9, 1999

MEMORANDUM TO ALL EMPLOYEES

RE: WHISTLEBLOWER PROTECTION

In 1989, the Whistleblower Protection Act was enacted to strengthen protections for Federal employees who believe they have been subjected to unjustified personnel actions in reprisal for their whistleblowing activities. In 1994, whistleblower protections were extended to VA's health care professionals appointed under Title 38. VA employees should be knowledgeable of the rights and protections accorded them by law.

Neither I nor any member of the leadership of this Department will tolerate whistleblower reprisal in the Department of Veterans Affairs. Each of us has an important role to play in promoting an environment in which employees feel free to come forward with their legitimate concerns without fear of reprisal.

Several years ago, the Department required that all investigative reports of complaints of reprisal be reviewed by senior executives, including reprisal for whistleblowing. Reports involving field facilities are reviewed by Network or Area Directors, or Associate Deputy Under Secretaries for Operations. For Headquarters, the review is conducted by Administration Heads, Assistant Secretaries and Other Key Officials. This procedure permits the determination of whether the personal intervention of VA's senior managers is required and ensures that appropriate action is taken when individuals are found guilty of reprisal. The above requirement does not apply, however, to reports of complaints of reprisal involving equal employment opportunity (EEO) discrimination. Allegations of reprisal in discrimination complaints, like EEO complaints themselves, should be brought to the attention of a VA Office of Resolution Management counselor at 1-888-737-3361, which is a toll-free number.

I encourage you to familiarize yourself with these protections and I remind every manager of this Department's responsibility to maintain a workplace that respects its employees' ability, indeed right, to raise legitimate concerns without fear of retribution. More detailed information about whistleblower protection is provided on the reverse side of this memorandum.

Togo D. West, Jr.

Whistleblowing and Whistleblower Protections

It is a prohibited personnel practice for an agency to subject you to a personnel action if the action is threatened, proposed, taken, or not taken because of whistleblowing activities. Whistleblowing means disclosing information that you reasonably believe is evidence of a violation of any law, rule, or regulation, or gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety. You are protected if you make such a disclosure to the Special Counsel or the Inspector General. You are also protected if you make such a disclosure to any other individual or organization (e.g., a congressional committee or the media), provided that the disclosure is not specifically prohibited by law.

Employees have a number of ways to challenge personnel actions they believe to be based on their whistleblowing activities.

- If the personnel action is appealable to the Merit Systems Protection Board (MSPB) (e.g., suspension for more than 14 days, reduction in grade, reduction in pay, or termination), the employee may raise the whistleblower concerns in the MSPB appeal. Information about MSPB appeal rights is available from your servicing Human Resources Management Office or by contacting the Clerk of the Board, U.S. Merit Systems Protection Board, 1120 Vermont Ave, NW., Washington, DC 20419.
- If the personnel action is appealable under a VA appeal procedure (e.g., title 38 disciplinary procedures), the employee may raise the whistleblower concerns in that VA appeal.
- If the personnel action is grievable under a negotiated grievance procedure contained in a labor-management agreement, the employee may raise the whistleblower concerns in the grievance.
- In some cases, the matter might also be appealable under VA's administrative grievance procedure (e.g., a non-bargaining unit employee's dissatisfaction involving a reassignment.)
- If the matter is not otherwise appealable to the MSPB (e.g., reassignment, non-selection, title 38 disciplinary actions), the employee may raise the issue with the independent Office of Special Counsel (OSC). The OSC can be contacted by calling the OSC hotline at 1-800-872-9855, or by writing to: Office of Special Counsel, 1730 M Street, NW., Washington, DC 20036-4505.
- Employees may also raise a whistleblower reprisal claim with VA's Office of Inspector General. The OIG Hotline number is 1-800-488-8244.

Information about appeal rights, and grievance procedures is available from your servicing Human Resources Management office. In addition, MSPB has published a pamphlet, *Questions and Answers About Whistleblower Appeals.* A copy of this pamphlet can be obtained from your Human Resources Management office or through the internet on the MSPB web site under MSPB Forms and Publications http://www.mspb.gov.

Mr. EVERETT. Finally, I want to thank all of our witnesses for appearing today, particularly those that came to share their personal experiences as whistleblowers. There is no point in pretending that they have faced anything other than a hard road as a result of their courage.

On behalf of the subcommittee, I thank them for their acts to protect our veterans and taxpayers from fraud, waste and abuse. Their only reward has been trouble and I am sorry for that.

They deserved much better. I hope that this hearing and what results from it will improve the situation for them and other whistleblowers within the VA.

I intend to ask the General Accounting Office, the independent investigation arm of Congress, to do a review and report on the effectiveness of the whistleblower protection provided to VA health care professionals when the Whistleblower Protection Act was amended in 1994 to include them. Changes in the law does not necessarily mean protection automatically followed. More appears to be necessary.

I also call upon the VA to give whistleblowers the protection they deserve and to hold those who retaliate against them severely responsible. Unless you send the message, it is just not going to get out there.

I can promise you this subcommittee is not going to lose interest in the issue, and there will be future hearings.

Thank you again.

This meeting is adjourned.

[Whereupon, at 12:55 p.m., the subcommittee was adjourned.]

APPENDIX

REMARKS FOR MS. BROWN
WHISTLEBLOWER HEARING
Wednesday, March 11

OPENING STATEMENT:

Thank you, Chairman Everett.

Congress has zero tolerance
for retaliation against whistleblowers.
None at all.

We need to protect employees
who uncover threats to the safety
of our veterans,
or crimes, or bad management.

Good administrators know that it is
better to listen
To whistleblowers who are mistaken
Than to silence the ones who are right.

We are here today to examine what
progress VA has made
since it came under the laws that protect
whistleblowers
nearly a decade ago.

**I am interested in today's testimony.
It is important that this hearing
stay focused
on the issue of whether
the whistleblowers have been punished
rather than on the substance
of what they have revealed.**

**We are limited today
to issues of retaliation.**

**It does not matter whether
the whistleblowers are right or wrong.
They cannot be punished for speaking
out.**

**Congress can measure the effectiveness
of whistleblower protection
primarily where it fails.**

**That is, VA has no statistics on how
often an employee says
"Boss, we've got a problem,"
and the boss calls a meeting
and gets the problem resolved.**

We have two ways to measure how well whistleblower protection works:

One is whatever information we can get from
- the Office of the Inspector General,
- the Office of Special Counsel and
- the Merit Systems Protection Board

on complaints and determinations.

The other is to listen to whistleblowers who feel the system has failed them.

VA has some of the finest,
Most dedicated employees in the world.

They must be confident that
They can go up the chain
And report incidents of mismanagement,
Fraud or other crime,
Or breaches of patient safety
Without fear of reprisal.

I look forward to hearing some day that
VA has awarded
a plaque or a promotion

to a whistleblower for saving lives
or money

or the integrity of a program,
even while threatened with being fired.

Perhaps that has already happened.

Today we will listen to the kind of stories
we hate to hear.
That is part of why we were elected.

Thank you, Mr. Chairman.

Statement of Honorable Lane Evans
Before the Subcommittee on Oversight & Investigations

Whistleblowing and Retaliation in
The Department of Veterans Affairs
March 11, 1999

Thank you, Mr. Chairman. I am pleased to be here this morning.

America protects whistleblowers for the same reason we protect free speech: We need the information about crimes, dangerous practices or gross mismanagement.

The written testimony of our witnesses has been helpful. Our focus today will be on what we can do to make VA employees safe in reporting problems that their superiors don't want reported.

Thank you, Mr. Chairman, I look forward to hearing from our witnesses.

STATEMENT FOR THE RECORD
BY THE HONORABLE ELAINE KAPLAN

SPECIAL COUNSEL

U.S. OFFICE OF SPECIAL COUNSEL

Before the

Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs

UNITED STATES HOUSE OF REPRESENTATIVES

[March 11, 1999]

Good morning. Thank you for inviting me to testify about the role of the U.S. Office of Special Counsel (OSC) in preventing reprisal for whistleblowing. OSC is an independent federal agency whose basic mission is to protect federal employees and job applicants from prohibited personnel practices, especially reprisal for whistleblowing. OSC receives, investigates, and prosecutes complaints of reprisal for whistleblowing before the Merit Systems Protection Board.

A federal civilian employee or job applicant is protected from reprisal when he or she discloses information which he or she reasonably believes evidences a violation of law, gross mismanagement, gross waste of funds, abuse of authority or a significant danger to the public health or safety. Reprisal for whistleblowing can take many forms including taking or failing to take personnel action or threatening to take or fail to take personnel action because of an individual's disclosures. Personnel actions may include written reprimand, reassignment of duties, removal, transfer, position nonselection, and/or lowered performance ratings.

By design, the Congress made OSC an independent and neutral body, and as such we represent neither complainants nor employing agencies. Rather, our client is the merit system. I was sworn in as Special Counsel in May 1998 to serve a five-year term, and my primary goal is for federal agency managers and employees to come to understand and appreciate OSC's role as an impartial advocate for the merit system.

Representing the merit system does not necessarily mean advocating on behalf of employees who allege that their rights have been violated. Instead, our job is to conduct an impartial investigation that should reveal whether a personnel action serves the efficiency of service or, instead, is tainted by improper motives such as reprisal for whistleblowing. If warranted, an OSC prosecution follows an investigation that reveals

the commission of a prohibited personnel practice unless the matter can be settled in another fashion.

To do our job effectively, we need the cooperation of other federal agencies. In principle, OSC's interests and those of the employing agency should be the same. All federal agencies should be interested in correcting and preventing illegal personnel actions.

At the present time, we do enjoy excellent mutually beneficial relationships with some federal agencies. I will single out the Department of Defense, the Army and the Navy, as examples of agencies that work as partners with us. These agencies have designated agency liaisons that we generally contact at the beginning of an investigation. The liaisons help us coordinate an investigation and often play an active role in brokering settlements and corrective actions when our investigation uncovers violations of law.

These agency relationships have developed over time and they are based upon mutual trust. The relationships benefit both the employing agency and OSC. The employing agency benefits because it has an opportunity to clean its own house. It also has a clear channel of communication with OSC to present its own concerns. OSC benefits because we will often expend fewer resources to successfully resolve a matter and we will resolve it more quickly than we would without the cooperation of the agency liaison.

One of the initiatives we are currently considering is to establish a more formal agency liaison program. We envision establishing a process by which we would train agency liaisons and enter into a formal agreement about our respective roles. We would use as our role model the system that the Office of Government Ethics has established for designated agency ethics officers. Part of the role of the agency liaison would be to help the agency meet its statutory responsibility to educate and inform employees about their rights.

Establishing a liaison program in highly decentralized agencies such as the VA, would present a formidable challenge. In our present day successful liaison programs, our contacts have significant influence on field activities and are very effective in convincing their field offices to take appropriate action. In order to replicate that in the VA, presumably, VA's headquarters would have to take a leading role in working with field installations.

In 1994, the Congress passed legislation designed to strengthen the Whistleblower Protection Act (WPA). That legislation did many things. It expanded whistleblower protection coverage to approximately 160,000 new employees, including 80,000 title 38 VA health professionals. It increased OSC's authority, duties and responsibilities. It gave all federal agencies the statutory responsibility to advise their

employees about their rights under the WPA, and directed that OSC play a consultative role in that process.

It appears that this key statutory educational responsibility has not been implemented in a serious fashion at a number of federal agencies, including the VA. Yet, we would all benefit if it were. If managers are given appropriate information and training in personnel matters, the federal government will be able to operate more effectively and employees will be able to focus on their mission.

Today, when new employees enter government service, they are usually given a packet of material regarding government ethics laws, family and medical leave, flex-time and other laws. I've yet to meet the new employee, however, who received a packet of information regarding prohibited personnel practices and the Whistleblower Protection Act.

I will point out that one federal agency -- the Customs Bureau -- recently mailed an OSC informational brochure on these subjects to each of its employees in a pay stub mailing. It did so to build whistleblower awareness within the agency at the direction of the new Customs Commissioner who wants to change the culture of the workforce and wants OSC to actively engage in training agency managers.

Awareness is very important. For example, in addition to our responsibilities to investigate and prosecute prohibited personnel practices, OSC also enforces the Hatch Act. Last year, we provided more than 2,000 advisory opinions on this Act, enabling individuals to determine whether or not they were covered and whether their contemplated activities were legally permitted. And, while we do receive and prosecute some Hatch Act complaints, they are very small in number as compared to complaints for whistleblower reprisal.

Before closing, I would like to provide an abbreviated summary of how OSC prosecutes complaints. We have a Complaints Examining Unit known as "CEU," which serves as our intake unit. It is staffed by 14 examiners who conduct preliminary investigations into about 2,000 complaints per year. These examiners include personnel specialists and lawyers. Through a committee process, where other lawyers and investigators participate, they determine whether a prima facie case has been alleged and whether further investigation is warranted.

In FY 1998, about 20 percent of the whistleblower retaliation complaints filed in the CEU were referred to our Investigation Division for further investigation. The remainder were closed. When a preliminary decision to close a matter has been made, the CEU sends out a preclosure letter to the complainant that spells out the reasons for the decision. The complainant may respond in writing to the preclosure letter and provide additional information within 16 days. In the interest of humanizing our agency as much as possible, and enhancing due process protections, I have also

instituted a policy where the complainant can request a telephone conference to discuss the preclosure letter with the CEU examiner.

When a matter is referred for further investigation by the CEU, an attorney and investigator are assigned to it who work as a team. The Investigation Division of OSC consists of 24 investigators and we have 10 attorneys in the Prosecution Division, although one of them works full-time on Hatch Act matters.

In 1998, about 25 percent of the cases referred for investigation were settled favorably for the claimant without formal litigation. These cases were settled either at some point during the investigation, after information supporting the complainant's claims was shared with the employing agency or, after the Prosecution Division decided that prosecution was warranted. Before OSC formally begins prosecution, we are required by law to send an explanatory letter to the agency head and request voluntary corrective and/or disciplinary action. Clearly, there is great value to settling a case. It avoids litigation costs and time.

I explain all this in the way of background because in looking at OSC, one should not look simply at cases pending before the MSPB. We seek relief for complainants through multiple channels.

Another key avenue of resolution of complaints which needs to be explored is Alternative Dispute Resolution (ADR). ADR might be extremely helpful to some of our complainants and the agency is exploring a pilot ADR program at this time.

In closing, I will offer a few comments as they pertain to the Veterans Administration. The bulk of complaints filed at OSC by VA employees involve either medical centers or hospitals. One issue this Committee might want to explore is what sort of personnel training, in terms of prohibited personnel practices and the Whistleblower Protection Act, have VA Medical Personnel Officers and Medical Centers Directors received? Are centers being run by Directors with a medical background but no personnel training? These are important questions for the Committee because whistleblower disclosures involving the VA health care system can involve serious public health issues.

Again, thank you for giving me the opportunity to be here today. We would welcome the opportunity to work with the VA in establishing whistleblower awareness and prohibited personnel practice training programs. We would also welcome its cooperation in establishing a liaison program with OSC.

STATEMENT OF
RICHARD J. GRIFFIN, INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HEARINGS CONCERNING
WHISTLEBLOWER PROTECTION

March 11, 1999

I want to thank Chairman Everett and the members of this Subcommittee for the opportunity to testify on the policies and protections of the Office of Inspector General (OIG), Department of Veterans Affairs (VA) for employees who engage in whistleblowing activities as well as for other employees who may be subject to retaliation for filing various types of claims or complaints against VA.

Each year the OIG receives thousands of complaints from VA employees who allege wrongdoing in VA programs and operations. Some of these complaints involve allegations of retaliation for whistleblowing. For example, since October 1, 1996, the OIG Hotline opened a total of 32 reprisal cases. Heavy workload required us to refer 12 of the cases to VA program offices for action. Of the 20 cases performed by the OIG, 4 remain under review, 3 were substantiated, 6 were unfounded, and 7 were closed during review because 1 sought remedy through the Federal Courts, 1 settled with VA management, and 5 went to the Office of Special Counsel (OSC).

Due to resource constraints, the OIG generally has had to limit its investigations to employees who believe they have been retaliated against because they filed a complaint with or provided information to the OIG, or to those cases involving senior VA managers. Whether we accept a case for investigation or not, it is OIG policy to advise all employees of their right to file a complaint with other administrative entities such as OSC, the VA Office of Resolution Management, or the Merit Systems Protection Board (MSPB).

Several statutes provide protection against retaliation to employees who make protected disclosures or engage in other protected activities. OSC has authority to investigate and take action on cases involving allegations of prohibited personnel practices as defined in Section 2302 of Title 5, United States Code. This includes personnel actions that are taken against employees and others who meet the definition of a whistleblower under the Whistleblower Protection Act (Public Law 101-12). OSC's authority also includes actions taken against employees who engage in other protected activities such as filing a grievance; testifying on behalf of another

employee who has filed a grievance or an appeal with the MSPB, or providing information to, or cooperating with, the OIG or other similar investigative entity.

Section 7 of the Inspector General Act of 1978 prohibits retaliation against employees who file a complaint or disclose information to the Inspector General (IG) concerning a violation of law, rule or regulation; mismanagement, gross waste of funds, abuse of authority, or a substantial and specific danger to the public health and safety. Other protected activities include exercising an appeal, complaint, or grievance right granted by any law, rule or regulation, or testifying for or lawfully assisting an individual who has exercised an appeal, complaint or grievance right.

Similarly, it is unlawful to retaliate against employees who have filed an Equal Employment Opportunity (EEO) discrimination complaint or have provided testimony on behalf of an employee who has filed an EEO complaint. Title VII of the Equal Employment Opportunity Act provides that employees who believe they were retaliated against have the right to file a claim through the EEO process. In VA, the Office of Resolution Management has the authority to receive and investigate these claims.

If the Office of Resolution Management determines that the employee was retaliated against for rightfully engaging in protected EEO activities, the Office of Resolution Management is required to report its findings to the Secretary of Veterans Affairs, who is required by statute to take disciplinary action against the supervisor or manager responsible for the personnel action.

Complaints to the Office of Resolution Management or MSPB have strict time limitations for filing that are not extended because the OIG is investigating the employee's retaliation complaint. I do not want any employee to be denied his or her right to due process under any of these systems because he or she failed to file a timely complaint or appeal. As such, it is OIG practice to inform all employees, who contact the OIG with complaints of retaliation, of their rights under the law.

At times OSC or the Office of Resolution Management contact us regarding their investigations of complaints of retaliation filed by VA employees who either filed a complaint or provided information to the IG during an investigation. My staff cooperates fully on these cases by providing records and other information in a timely manner.

The enforcement authority for each of these administrative bodies is broader than the authority of the IG. For example, if OSC finds that the agency has taken a personnel action because an employee engaged in a protected activity, such as whistleblowing, it has the authority to request the Secretary to take appropriate corrective action. If

the agency declines to take what OSC believes is appropriate corrective action, OSC has statutory authority to file a complaint, on behalf of the employee, with MSPB.

In any case in which MSPB concludes that the agency retaliated against an employee for engaging in protected activities, it has the authority to order the agency to take specific corrective action. This includes not only awards of back pay and benefits to which the employee may be entitled, but also ordering specific disciplinary action against the retaliating official(s). MSPB decisions may be appealed in Federal Court.

In cases where our investigation substantiates allegations of retaliation for whistleblowing, we recommend that management take appropriate disciplinary action against the wrongdoer and corrective action to make the employee whole. With our recommendations, we provide VA management with the basis, including testimony or affidavits provided by other employees, that supports our findings. The agency needs this evidence to make a determination whether disciplinary action should be imposed and, if so, what type of action is appropriate under the circumstances. In addition, in most cases, the agency is required to prepare an evidence file supporting the charges, which is given to the employee when the action is proposed.

In those cases where VA management takes administrative and/or disciplinary action based on an OIG recommendation, the OIG considers the case closed. This is in accordance with standard practice in the Inspector General community. The decision whether to take administrative action, and the specific action that is appropriate, is vested in the management officials who supervise the employee in question. Because Offices of Inspector General are independent of management, they do not recommend specific penalties or disciplinary actions. The OIG's function of objective oversight makes it especially important that the line between management responsibility and IG oversight responsibility be respected and maintained.

In those cases where the VA program office does not agree with OIG findings and recommendations, and after every attempt is made to resolve such disagreements at the program office level, the OIG would use, and has used, the formal resolution process within VA, where the Deputy Secretary is the deciding official. When the OIG investigation concludes that the agency did not retaliate against the employee, we advise the employee of the results of our investigation and remind them of their right to file a complaint with OSC.

We are aware that some VA employees are reluctant to raise allegations of wrongdoing or cooperate with the OIG because they fear reprisal. Fear of reprisal is a natural reaction and will always exist to some degree. However, in my view, fear of retaliation which has the potential to deter complainants from coming forward with

allegations of wrongdoing is an issue that needs to be continually addressed within VA through timely and credible reviews by the OIG followed by appropriate administrative actions by the Department's managers. Continuing education, such as including discussions on whistleblower protection in annual training sessions for senior managers, can also play an important role in increasing awareness.

In the past few years, we have been involved in several investigations in which facility managers have made statements to employees that have been perceived as threats against employees who go to the IG with a complaint or provide information to the IG or other outside persons or entities. Notwithstanding whether management intended to or not, such statements intimidate employees and discourage them from being forthcoming and cooperative in our oversight efforts. These statements range from memorandums or policies requiring employees to contact management before and after the IG interviews them, to statements indicating that the IG will not always be around to protect them after the investigation is concluded.

When statements of this nature come to our attention, we take action to have them rescinded and to have VA officials take appropriate action against the managers who may be impeding an IG investigation through intimidation. We insist that any retraction emphasize that any VA employee is free to contact the IG at any time with complaints of fraud, waste, abuse, and mismanagement, and is legally protected from reprisal for doing so.

To encourage employees to come forward with complaints of fraud, waste, abuse, etc., Section 7 of the IG Act requires the IG to maintain the confidentiality of employees who file a complaint or otherwise provide information to the IG. This section provides that the identity of the employee cannot be released except if the IG deems it absolutely necessary to conduct the investigation.

It is OIG policy to consider all VA employees who contact us with a complaint as a confidential source, unless the employee advises us that he or she does not expect or want to remain confidential. However, there are occasions where employees would like to remain confidential but the very nature of the complaint makes it impossible to conduct an investigation without explicitly or implicitly identifying the complainant.

For example, an employee may file a complaint containing allegations of mismanagement that the employee previously brought to the attention of VA management. The mere fact that we are investigating the same allegation could lead management to suspect that employee. Another example involves allegations of retaliation, which by their very nature cannot be investigated without revealing the name of the employee. In situations such as these, it is OIG policy and practice to

advise the employee that we cannot guarantee confidentiality if we conduct an investigation and we then allow the employee to decide whether he or she wants us to conduct an investigation or close the case.

The issue of whether VA disciplinary action for senior managers was addressed at an appropriate level has been the subject of congressional hearings in recent years. For example, in early 1997, hearings were held to discuss VA's policies and practices regarding sexual harassment in the workplace. In response to concerns expressed about the appropriateness of the disciplinary actions taken against senior managers, VA announced that the Secretary established a new approach for dealing with recommendations for disciplinary action involving senior VA executives. The approach, established in March 1997, requires the Office of the Secretary to be informed of any proposed actions related to conduct or performance problems, involving positions centralized to the Secretary, before the proposal is implemented.

This approach was developed to help ensure an appropriate level of punishment, and to overcome the perception that past disciplinary actions against some senior managers fell short considering the seriousness of the infractions.

Making the punishment fit the crime, as it were, serves not only as a deterrent to further wrongdoing by all levels of VA employees, but particularly by senior officials who have the greatest capability to harm VA because of their high level positions and corresponding influence on the organization. Secondly, it sends a message to all employees that they can make a difference in disclosing wrongdoing, and any official retaliating against them will face appropriate consequences.

In closing, I want to thank the committee for its support, particularly in the FY 1999 budget. The additional resources you provided will be extremely helpful in improving our ability to issue timely and thorough reports. If these actions are combined with a commitment by the Department to have prompt, appropriate administrative action, we can improve the quality of the workplace for all VA employees, and as a result, improve the quality of service to our veterans.

That concludes my statement. I would be happy to respond to any questions you have at this time. Thank you.

WRITTEN TESTIMONY OF

Donald R. Bumgardner

Central Alabama Veterans Health Care System

I feel honored to come today before such a distinguished body. I also feel honored to be among other individuals who chose, as I did, to become a whistleblower. I hope in the brief time allotted I can assist you in understanding the plight of a whistleblower in the federal government.

I am here today representing many of my colleagues who are unable to be here. Some have remained in the federal government while others were unable or unwilling to remain. Many talented individuals with valuable years of experience were forced to leave federal service. The loss to those individuals has also been a loss to the federal government.

I met with Congressman Everett and his District Director, Steve Pelham, in Montgomery, AL in May 1997. In my position as Financial Manager, I had acquired evidence of mismanagement in the merger of the Montgomery and Tuskegee VA medical centers. I passed to Congressman Everett the following:
(1) Evidence of overtime usage between the two campuses.
(2) A list of promotions.
(3) A partial list of renovations planned for the Tuskegee campus.
(4) One of Mr. Jimmie Clay's e-mail messages on "Resistance."
(5) A report showing sick leave usage at Tuskegee of approximately 85% of sick leave earned.

I met again with Mr. Pelham on June 2, 1997 to pass a second package that consisted of:
(1) The Central Alabama Veterans Health Care System (CAVHCS) Master Space Plan showing $8 million in renovations, $7.6 million to be done at the Tuskegee campus.
(2) Fiscal Year 96 overtime comparisons of hospitals similar to Tuskegee showing excessive overtime usage by Tuskegee.
(3) Overtime for pay period ending 6/2/97 showing Tuskegee using $47,654 and Montgomery using $4,183.

The integration was halted on June 10, 1997. The suspension of the integration at CAVHCS received significant coverage in the local newspapers and on television. The issues of excessive overtime, sick leave usage and renovation costs, about which I had informed Congressman Everett, were discussed in detail. While I was not specifically identified in any report, the nature and specificity of the information provided would leave one to realize that there were few individuals at CAVHCS who had access to all this information. It was natural that I would be suspected as a likely person to have provided information.

Within a week of the June 10, 1997 halt to the CAVHCS integration at the request of Congressman Everett, Mr. Jimmie L. Clay, former Director, CAVHCS appeared on a local TV call-in program in Tuskegee. Mr. Clay made references to trouble at CAVHCS. He referred to a group of two or three people who had made allegations against him. He stated one in particular, a white male who was unhappy because he did not get selected for a position. Mr. Clay stated he selected the best-qualified candidate, a black female. The only situation in the medical center where this had happened involved me. This was for the position of Chief, Informatics. This left no doubt in my mind or anyone else's that he was referring to me.

Other employees within the organization felt the heat for being close to me. The former Chief, Human Resources Management, Mr. Russell Paine, sent a memo dated June 18, 1997 to Mr. Clay denying any acts of whistleblowing. He felt that rumors circulating naming him as a whistleblower would injure his chances for any future career aspirations with the agency. Mr. Paine was my best friend at CAVHCS. Sadly, he was one of many government employees who left because he could not tolerate the violations of rules by management.

I continued to meet and talk with Mr. Pelham and supply information to his office. I later met with different representatives of the VA Inspector General and the Federal Bureau of Investigation.

My relationship with Mr. John Hawkins, former Associate Director, did not begin smoothly. Shortly after Mr. Hawkins joined CAVHCS, I had to discuss with him illegal charges to his government charge card. He had made several charges to local vendors which had nothing to do with temporary duty travel. Upon review, he had made similar charges while he was at Saginaw, MI.

Mr. Hawkins asked my opinion, as a Financial Manager, about having a picnic in lieu of an awards program. I stated under applicable rules, there were limits on what he could do. He stated that it was easier to get forgiveness than permission. When information about the cost of the picnic was leaked, it was cancelled. I understand I was one of the people blamed for its cancellation.

I soon found that I was being treated differently by higher management at CAVHCS. In mid-June, Mr. Hawkins informed me he wished to abolish my compressed tour. I was able to delay this action until August. During July 1997, I had to go on medical leave for back surgery. The standard practice in a situation where a service chief had to take leave was to appoint the assistant chief as Acting Chief until the chief returned. Instead, Mr. Hawkins issued a memo which stated, in part, "Effective today and until further notice, the primary responsibilities for Fiscal Service operations for both campuses will be transferred to Mr. Robert Finney, Chief, Fiscal Service at the East Campus." The memorandum was never rescinded and when I returned from sick leave my former authority was never returned.

Further actions continued to take place in retaliation against me. I had to move my office from the main building to an outlying building. I was later informed the timing of this was only to inconvenience me. A refrigerator assigned to my service was transferred to the Director's office. The refrigerator was used for storing lunch and other perishables for my staff. This action served no purpose except to inconvenience my staff. Software that I needed on my computer was inordinately delayed being installed. Without this software, I was unable to communicate with other Financial Managers.

In August 1997, I applied for the position of Financial Manager at CAVHCS. This position was the result of combining the Financial Manager positions at Montgomery and Tuskegee. I had been the Financial Manager at Montgomery for approximately nine years, and had twenty years as a service chief. I am a Certified Governmental Financial Manager as awarded by the Association of Government Accountants. On my Supervisory Appraisal of Employee for Promotion, I received a rating of 30 out of a possible 30 on my Knowledge, Skill, Abilities and Other Characteristics. I had Outstanding ratings the last two years on my performance ratings. As you can expect without my going into a lot of facts, I was not chosen for this position. Mr. Hawkins chose a black female, Mrs. Regina Carden, who had previously worked for him at Saginaw, MI.

I arranged a meeting with Mr. Pelham in November 1997 for eight CAVHCS service chiefs who were also passed over for selection. We discussed the composition of the panel to review candidates; the interview process; the lack of subject matter experts; and, the inclusion of the union to not only ask questions but participate as full voting members. The service chiefs from CAVHCS had all previously dealt with the union over grievances and other related personnel matters. We were at a distinct disadvantage in being selected by a panel with this makeup. In my particular case, one of the management representatives on the selection panel was the black female that was selected by Mr. Clay as the Chief, Informatics. We discussed that five of the service chiefs were veterans being replaced by non-veterans. The Office of Inspector General initiated another review at the behest of Congressman Everett.

On December 4, 1997 I sent a package of information to Congressman Everett, Senator Richard Shelby and Senator Jeff Sessions. One part of the package consisted of travel authorities for the six service managers Mr. Hawkins selected to administrative positions within CAVHCS. Mr. Finney supplied me with the travel authorities. Estimated moving expenses for the six transfers exceeded $327,000. Salary and benefits would exceed $430,000 before the January 1998 pay raise took effect. CAVHCS was expending over $757,000 to sometimes double or triple encumber positions. Mr. Hawkins confronted Mr. Finney when it was discovered the travel authorities had been copied. Mr. Finney refused to state to whom he released the documents and received a proposed five-day suspension that was later rescinded upon the intervention of Mr. Finney's attorney.

I met with Mr. Hawkins on December 8, 1997. I asked to tape the meeting so I could have an accurate account of what was discussed. He asked why I felt I should have to tape our meeting. I stated that I was disturbed by his comments made in a November 4,

1997 Director's Staff Conference (he had made overt suggestions that when the IG departed there would be retribution, and then prepared a December 4, 1997 memo to undo the damage he had done.) He acquiesced to taping the meeting. He gave me a memo assigning me to the Tuskegee campus as a Staff Assistant/Accountant. I was to clean out my office and report by December 10, 1997. When I asked him to explain the reason for the reassignment and relocation, Mr. Hawkins refused to answer and reached over and turned off the tape recorder. Then he declared the meeting was over. I reached into my pocket and pulled out a second tape recorder and again asked for an explanation. Mr. Hawkins balled up his fists while standing over me and asked whether I would leave or would have to be made to leave. I told Mr. Hawkins I would leave.

On December 9, 1997 all my computer access with the exception of local e-mail and leave request was pulled. The same day Mr. Finney informed me the door had been removed to the office I was to occupy at Tuskegee.

I turned to Congressman Everett for help. I informed Mr. Pelham of what had taken place. He assured me he would inform Congressman Everett and action would be taken.

I prepared and forwarded a memorandum to Mr. Clay appealing my position reassignment. I met with Mr. Clay on December 12, 1997 and was informed that Mr. Hawkins' memorandum would be rescinded.

I know Congressman Everett interceded on my behalf. I do not wish to know what may have happened if he had not. This was a really low point in my life. I also sought treatment by my family physician. Dr. Lois Shulman insisted on giving me a complete physical. I was having trouble sleeping. I felt I had brought a great burden upon my wife and family. My temper was short and the norm for me was to come home and sit. My health deteriorated. Dr. Shulman prescribed medication to allow me to sleep at night. I would like to state I only took three days of sick leave before I returned to duty. When I returned, I was never given a position description or any appreciable duties to perform. I feel the actions Mr. Hawkins took were to provoke me to leave federal service. There was buyout authority available and I met the minimum requirement to accept it. I could not afford to leave then or now.

I only met on a few occasions with Mrs. Carden. On each occasion, I would have to prepare a Report of Contact for verification of what had been stated. I found communication with Mrs. Carden to be very difficult. Mrs. Carden stated that when some moves were completed, I would share an office with her on the Montgomery campus.

Management went so far as to later reverse personnel actions that were taken before I was removed from a supervisory role. In March 1998 Ms. Angelia Lassiter, with a Masters Degree in Accounting, was removed as an Accountant, GS-7 and reassigned as an Accountant Technician, GS-6. She was in a series for promotion potential to a GS-9. Mr. Jesse Raymond, EEO Investigator, effectively told me this action directed against Ms. Lassiter was because management was unable to touch me. Ms. Lassiter has since

transferred to another Veterans Affairs Medical Center, the loss another casualty for CAVHCS.

The integration was designed to save precious medical care funds to expand programs for the veterans we were responsible with serving. As a financial manager, I was a steward of the budget. I was charged with ensuring that the waste, fraud and abuse statutes were carried out. I first discussed the overtime usage at Tuskegee with Mr. Clay in January 1997. Nothing was ever done to decrease its usage. I tried for five months to work for change within the organization. The way the organization was going ahead without any regard for obeying rules and regulations made my decision much easier. I feel I did what was right. I have no regrets.

In September 1998, the Office of Inspector General report on Management, Clinical, and Administrative Issues at CAVHCS was released. On page 59 the report reads, "Based on our analysis of the facts, we concluded that Donald R. Bumgardner's nonselection and permanent change of duties was in retaliation for making protected disclosures and for filing an EEO complaint which are prohibited personnel practices under paragraph 2303 (b)(8) and (b)(9) respectively. I feel exonerated by the OIG that they recognized what had happened to not only myself but others at CAVHCS. I am currently awaiting the resolution of both an Equal Employment Opportunity and Office of Special Counsel investigation. Without some resolution to either one of these situations, I am not sure what my future holds. I have not received favorable rulings to two EEO complaints that have been filed over non-selection to CAVHCS positions.

Mr. Ken Ruyle, current Acting Medical Center Director, detailed me as a Special Assistant to the Director in June 1998. I am presently working on the station Performance Measures, monitoring overtime and sick leave usage and working on special projects as assigned. This detail will end in June 1999. I will carry the label of being a whistleblower for the rest of my career. I am sure any chance for future advancement was over once I stepped out as a whistleblower. My desire to remain in federal service until I am 62 years of age or I was ready to retire doesn't seem possible. I have accepted the fact that I go to work knowing that day could be the last one I work. It is a very sobering thought.

I continue to be a topic discussed in anonymous letters that attack Mr. Ruyle for the changes he has implemented at CAVHCS. I have prepared myself that when the texts of my oral and written testimony here are released, these attacks will intensify. The resolution of Messrs. Clay and Hawkins' status could resolve some of this. I call on the Secretary, Department of Veterans Affairs to conclude this chapter to CAVHCS. These two individuals and the medical center need a closure to this.

Statement of Kenneth Wilson

Members of the Committee, my name is Ken Wilson and I presently am employed at the VA Medical Center in Tuscaloosa, Alabama. My federal service began with three (3) years in the U.S. Navy and twenty-seven years with the Veterans Administration. My career with the VA began as a GS-3 Supply Clerk and after various moves to seven (7) Medical Centers, I obtained the title of Chief, Acquisition and Materiels Management Service My reason for being here today is to provide a brief synopsis of the events that led to my being eliminated from my career field and placed in a status of not having a position description nor a defined job assignment

The VA Medical center, Montgomery, Alabama became my duty station in July of 1988. My position of Chief, Acquisition and Materiels Management Service required me to be an integral part of the day-to-day administrative effort to strive to ensure the best possible care to this nation's veterans through support to the clinical care providers at the Montgomery VA. In this effort, I received numerous outstanding performance ratings and awards for my efforts.

In 1996, it was determined that the VAMC, Montgomery and VAMC, Tuskegee, Alabama would be consolidated into the Central Alabama Veterans Healthcare System. In late December 1996, my counterpart at the VAMC, Tuskegee left federal service and I was asked to manage both Medical Centers' logistics operations In March of 1997, the Acting Director of the combined Medical Centers, Mr. Clay, presented me with an outstanding performance award. In the fall of 1997, the position of which I occupied was advertised nationally and I in effect applied for my own job. This process also took place for other service chiefs serving at both VAMCs I was advised by the Associate Director, Mr Hawkins, that I was not selected for the position. My questions to the Associate Director, what qualifications did I not possess to be selected and/or what leadership skills did I not have to be selected were not answered except to say I was fully qualified but he, Mr. Hawkins, wanted his own man in the job. I asked what my new job would be but was not given an answer. I did receive a memorandum informing me that I would be an Administrative Assistant to the new chief. In January 1998, I chose to transfer to another VA to remove myself from this situation.

My failure to be selected was and still is the results of my being part of a group of employees who cooperated with the VA IG Investigation into the integration and my association with Congressman Everett's Office in the review of this integration process. My non-selection also stems from my not cooperating in the expenditure of funds for a function that violated regulations. Before my removal as Service Chief, I was instructed to write a purchase order for a "picnic" for employees of the combined VA Medical Centers at Montgomery and Tuskegee. The cost of this "picnic" would have totaled just under $25,000 for food and entertainment. I informed the Associate Director, Mr Hawkins, that this transaction was illegal and could not be accomplished within the regulations. I was given a copy of an agreement signed by Mr. Hawkins that detailed what was to be provided by the vendor and repeatedly told to write the purchase order. My refusal to act on this matter lead to my conferring with the Network Acquisition Office for advice and guidance. The picnic was cancelled the day before it was scheduled. This situation lead to my being labeled as "not a team player" and being against the integration process.

After this incident and numerous others mentioned in the VA OIG Report took place, a group of employees chose to contact Congressman Terry Everett's Office for assistance. To this day, if it had not been for the intervention by Congressman Everett, this situation would have continued to deteriorate and brought down the level of patient care to an unacceptable level To this day, the situation at Central Alabama Veterans Healthcare Systems remains unsettled and in turmoil. No end in site

Without reliving all the details of the integration of the VAMC Montgomery and Tuskegee, please allow me to say that there is no provisions in the VA System to protect those employees who cooperate with the VA Office of Inspection General. There is no mechanism to stop the injustice to employees who attempt to prevent the gross mismanagement of VA activities The attempts to make higher level officials aware of these activities fall on deaf ears. Middle management staff are at risk every day in the performance of their

duties, of being singled out or grouped together as undesirable and their careers are over

Some of the CAVHCS employees chose to resign and find other jobs, some chose to "early out" and reduce their retirement benefits, others chose to give up their homes and VA family and seek other VA positions, some chose to stay and be subjected to a multitude of harassing and embarrassing situations. Some chose to pursue the EEO System for resolution, some (who could afford it) chose to hire legal counsel to seek relief, some chose to walk away and give up, some of us still hold out with a faith in our VA System will correct these wrong doings and compensate those effected by these actions To date, the system has managed to loose quite a few dedicated, loyal employees who cannot be replaced easily, the system has completely shattered the pride of many employees who have spent their adult lives in the VA System. The system has not only failed those employees, it has failed the veterans these employees have served long and faithfully for

In closing, I would hope that through these hearings, that some mechanism will be developed in ensure that employees of this agency have some avenue of protection and that policies are defined and carried out equally and fairly
My thanks to the Committee for this opportunity to speak, and to Congressman Everett for his role in this situation. I was asked if I had any reservations about testifying before this Committee, my reply was - gone is my career field, my job, my VA family, my home, my faith in the system that I've spent 27 years in, what else can I loose

TESTIMONY ON WHISTLEBLOWING AND RETALIATION WITHIN THE DEPARTMENT OF VETERANS AFFAIRS PRESENTED BY JOAN PASTOR BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES VETERANS AFFAIRS COMMITTEE, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS ON MARCH 11, 1999.

Good Morning My name is Joan Pastor Mr Chairman, members of this committee, I feel honored that you asked me to be here today. I just wish that my invitation were under different circumstances.

I was asked here today to tell you about the retaliation that I experienced after reporting a number of ways my supervisor, W Bruce Dunkman, MD ,at the Philadelphia Veterans Administration Medical Center (VAMC) violated state and federal laws, rules and regulations and actions that posed a substantial threat to the health and safety of the hospital patients. I was a research nurse at the Philadelphia VAMC in the Special Cardiology Clinic, working on NIH and Pharmaceutical Company sponsored clinical research studies from August of 1995 to May of 1998 During my tenure, I was harassed, intimidated, slandered, excluded from my job and ultimately dismissed from my position for trying to help and protect the patients in the clinic.

The retaliation began in August 1996, after a male Pulmonary Function Technician sexually attacked me My supervisor, Dr. Dunkman, blamed me for the assailant's actions. After repeatedly pleading with my supervisor to not allow this man to work in my office area, my supervisor had the perpetrator brought to my office and said "You do not make the rules around here, I do". After discussing with Dr. Dunkman how physically threatened I felt in the assailant's presence, my supervisor repeatedly threatened to bring the assailant over to my work area, told me that my sex life would be exposed if the sexual attack was reported and threatened to fire a research nurse (insinuating that to be me) He added that the perpetrator's attack was a romantic gesture and men who kiss their victims do not try to rape or kill them.

My supervisor never told me about the Equal Employment Opportunity (EEO) process nor did he report this incident to the EEO office or to other management officials My supervisor exclaimed that the assailant was a tech that he did not want to lose. I asked my supervisor if the perpetrator could be moved to another area of the hospital. Dr. Dunkman replied "NO" I then asked to use one of the empty offices farther from the assailant's work area but my request was turned down and I was told that I was asking for too much.

My supervisor did not make any accommodations to decrease the possibility of this man physically attacking me again The assailant remained in his office across the hallway from my office area and was not moved to another work area, until after I reported the attack and my ongoing fear to Human Resources in February, 1997

For six months, I endured my supervisor's repeated threats of possibly bringing the man that attacked me into my office area. Finally, after my supervisor pounded his fist on the desk and demanded that I leave my office area so the assailant could come over to my area and take over one of my job responsibilities, I went to Human Resources. I felt terrorized by my supervisor because his actions of bringing the assailant to my office, pounding on the desk, blocking my office doorway so I could not exit and walking closely behind me down the hallway were aggressive acts and indicated his escalating anger.

I went to Human Resources (in February of 1997) to inquire about other positions within the hospital The Acting Human Resource (HR) Director, asked me why I was exploring new opportunities I made several disclosures to the Acting HR Director that included:

* the sexual attack,
* Dr Dunkman not reporting the incident to management,
* Dr Dunkman repeatedly exclaiming that he was going to bring the assailant over to my office area;
* Dr. Dunkman having the assailant brought to my work area;
* Dr. Dunkman's medication redistribution practice from one patient to another, and
* Exposure to radiation during a research study.

The Acting Human Resource Director requested that I write a statement summarizing our discussion. I did so in an effort to protect not only myself but also the patients.

After I delivered my report to HR, the medication redistribution "stash" was removed from the clinic by a health care team that consisted of the Chief of Pharmacy, Police, Chief of Medical Services and her assistant. Dr. Dunkman had been redistributing medications from one patient to another for years. These medications being distributed in the clinic had already been dispensed to other patients, been handled and some were obviously dirty and were expired or past their expiration dates and were not to be consumed but Dr. Dunkman distributed the medications, anyway. Dr. Dunkman never kept records of the medications he distributed in his redistribution scheme or to whom they were distributed.

After the medication "stash" was removed by the health care team, the Acting Human Resource Director

told me that my safety was in jeopardy at the Philadelphia VAMC and that I should not return to work After I told the Acting Human Resource Director that I wanted to come back to work, she presented three alternative positions for employment The positions presented were

* doing filing for the secretary in research services,
* answering phones for a clinical research nurse or
* being a technician

None of the positions required my skills or educational background of a BS in Chemistry and BSN in Nursing.

Upon my return to work, I was isolated in an office in the basement and not given anything to do. I was not even permitted to do the paperwork associated with my job I objected to this and decided to return to my previous position even though no safety measures were afforded me I spoke to the Acting Human Resource Director before I returned to the research clinic and she gave me the number of the police and told me to call them if anything happened.

When I returned to my office, my supervisor, Dr. Dunkman, repeatedly yelled at me "to get another job" If I asked him a question about the work that needed to be completed he would ignore me or tell me that he did not have time to answer my question. Dr. Dunkman excluded me from the daily clinic meetings and denied my access to research study files He would meet with my co-worker behind closed doors and would stop talking if I entered the room Dr. Dunkman then resorted to lurking outside my office door during the workday to listen to any possible conversations inside.

I had previously been allowed to attend clinical research study meetings and graduate school at the University of Pennsylvania. After reporting my supervisor's wrongdoing, I was permitted to attend meetings for only one of the three studies being conducted in the clinic. Dr. Dunkman did not allow me to attend and/or perform duties related to the other studies that listed my name as a clinical research coordinator. Dr Dunkman also tried to deny paying for one graduate class per semester which was a benefit agreed upon during the time of my hiring at the Philadelphia VAMC

Dr. Dunkman enlisted help from my co-worker and others inside and outside of the hospital to retaliate against me Initially, Dr Dunkman requested my co-worker to keep track of my time and record it. My co-worker determined that if the door to my office was closed then I was not present at work and he could mark me absent

I had inquired about the inaccurate recording of my time in the computer. Mr Robert Lyle, Administrative Officer for Research began to scream at me for questioning the records. He said that if I was not at my post then I would be marked absent. I was shocked that he was yelling at me because I had had a good relationship with him previously

In April of 1997, I was referred to Ms. Ann Lovell, the Radiation Safety Officer (RSO) at the Philadelphia VAMC (PVAMC), to discuss and determine the degree of my radiation exposure during a clinical research study. I had worried for a year and a half about the radiation exposure but had never known whom to consult about it. After I reported that I was a radiation worker to Human Resources and that Dr Dunkman had neglected to send me to radiation safety training, I was given the appropriate training and my radiation exposure was estimated.

Since the RSO had not been aware of the clinical research I was doing, we reviewed the informed consents and protocols. Ms. Lovell and I discovered that the research studies had not been approved by the Radiation Safety or the Biohazard Committees as was required by the license granted by the Nuclear Regulatory Commission (NRC) and the PVAMC regulations

Since the radiation experts within the hospital had never calculated the dosage of radiation received by the patients in the study, the informed consents either neglected to state or under-estimated the amount of radiation that the research patient would receive during the protocols. I notified the Hospital Director, Mr. Earl Falast of the inaccuracies in the research study's informed consents because I felt that this matter was of a serious nature and required his attention Mr. Earl Falast never replied back to me about my memo. After this issue was further investigated one of the on-going studies required all 90 hospitals (30 VA and 60 non-VA) conducting that research to change their informed consents to reflect a more accurate calculation of the radiation exposure of the research patients.

In May of 1997, my co-worker, aided by my supervisor, filed criminal charges against me with the PVAMC police charging me with taking patient files because they could not be located. I was on vacation the day the charges were filed but was available by phone. When I returned to work the next day, Dr Dunkman stated that he had filed criminal charges against me for taking missing patient files. I showed Dr. Dunkman that the files were beside the other research files where they had been for months After inquiring further as to why Dr. Dunkman and my co-worker filed criminal charges for not being able to locate patient files, my co-worker began screaming at me and came within four inches of my face without Dr. Dunkman so much as chastising him for his anger. Meanwhile, I had to endure the humiliation and

slanderous repercussions of having been the subject of a police report.

Dr Dunkman and my co-worker worked in synergy telling other employees and patients that I was not doing my job and that I was trying to close the clinic I heard Dr. Dunkman tell a management official that I was psychotic and a co-worker reported that Dr. Dunkman told them that I was crazy

I was very upset that Dr Dunkman tried to slander me to cover up for his wrongdoing I only reported his actions because the patients' health and safety were at stake I made him aware that his actions were against federal rules and regulations. But he repeatedly refused to abide by the structures that were set up to protect patients and employees

I went to the PVAMC's medical ethicist to discuss the ethical issues pertaining to the misleading and inaccurate statements contained in the informed consents for the research studies. The Philadelphia's VAMC Medical Ethicist was not only the ethicist but also a member of the Institutional Review Board (IRB) Although she was outraged that the informed consents were inaccurate and that the necessary approvals for the research were never obtained, she said that she could not say anything to the IRB, the committee that approves the research in the hospital, because she feared she would lose her job. She further explained that she needed the financial income for her daughter's college tuition and the VA's health insurance benefits

In May of 1997, the FDA audited the "Special Cardiology" clinical research site Dr. Dunkman demanded that I only essentially answer "yes or no" to the FDA investigator's questions. I placed a revised Informed Consent for one of the research studies in the Regulatory Binder during the audit as required by the study's clinical research associates. Dr Dunkman became very upset with me because he thought that the FDA inspector might have noticed the changes in the informed consent regarding radiation and that it had been improperly approved by expedited review. According to the FDA regulations, the informed consent on studies utilizing radiation could not receive expedited review The FDA auditor never seemed to notice this violation and it was not noted in the #483 report, Findings of the FDA Audit.

During the FDA audit, the investigator questioned me about the delinquent and absent reporting of patient deaths and serious adverse events in the research study The FDA regulations and the study's protocol state that research patient deaths must be reported to the study sponsor within 72 hours and to the FDA within 10 days I reported to the FDA auditor the names of the patients and dates of the existing reports. Many of the required reports had not been filed. Dr. Dunkman busied himself trying to complete them during the audit and backdated them. The FDA caught him in the act but to my knowledge never did anything about it. The most frustrating part of being a whistleblower has been that the agencies responsible for correcting the wrongdoing often do not take any action to enforce their own laws, rules and regulations In this situation, the FDA has gone so far as to say that they have an **unwritten rule** that study patients who die in the course of protocol allegedly not caused by the study medication as determined by the researcher do not have to be reported to the FDA.

The Nuclear Regulatory Commission (NRC) came to the Philadelphia VAMC to inspect the facility beginning in 1996 and continued through 1997. The NRC inspector interviewed me about the unapproved clinical research being conducted in the facility. Although the NRC auditor knew that the violations of conducting research without proper Radiation Safety and Biohazard Committees review and approval was contrary to the NRC license of the Philadelphia VAMC, she warned me that my reporting of these violations would ruin my career. In a follow-up letter to me from the NRC, the NRC stated that clinical research did not fall entirely under their jurisdiction and therefore the FDA would be consulted on some of the issues I had raised The investigations by both agencies, the FDA and the NRC, are still open on those issues today.

Beginning in June of 1997, Dr Dunkman repeatedly consulted the hospital administrator, Director and Human Resource personnel to find a way to terminate me. Dr. Dunkman announced in the hallway to the Chief of Cardiology that he was going to Human Resources to find a way to terminate me. Dr. Dunkman told my co-worker that he was going to terminate me but that it would take time. He wrote a memo to Ms Meg O'Shea, Associate Hospital Director, indicating his wish to eliminate me due to my whistleblowing Dr. Dunkman stated in a deposition that he knew that the traditional route of termination could be a lengthy and a laborious process indicating that another avenue was preferred.

In September of 1997, I was again exposed to radiation without my consent or knowledge. My co-worker left a radioactive blood sample in my office area at the desk where I often sat. This specimen not only contained radiation but was also hazardous waste The co-worker had been previously instructed to draw blood prior to patients being injected with radiation to limit potential exposure. Yet he neglected his training and drew radioactive blood from a patient and then left the blood in my office area This co-worker had performed blood draws numerous times before and had never left the blood in my office area before this date. It was therefore either grossly negligent or purposeful. Dr. Dunkman did not chastise, discipline or retrain my co-worker for this dangerous action.

I attended the September, 1997 Radiation Safety Committee meeting At the meeting, the Chief of Radiology yelled at me in front of my peers and management officials to get another job. Subsequent to the meeting, Dr Dunkman admitted that he had asked the Chief of Radiology to tell me to get another job.

Dr. Dunkman continued his campaign to elicit help to intimidate and harass me into getting another job Dr. Dunkman had said that I had been awarded a four-year term appointment that could not be terminated easily; therefore he had to get me to quit. He went so far as to instruct a non-PVAMC employee, a clinical research associate working on a study for which I was the study coordinator, to tell me to get another job She told me this in a derisive manner

Dr Dunkman would scream at me saying that I was only at the Philadelphia VAMC to collect a paycheck and that I did not want to work. Yet he had been pleased with my performance prior to my making the protected disclosures To assure that I was adequately performing my duties, I had repeatedly asked for performance appraisals but I never received one despite the fact that my co-worker did receive one. Dr Dunkman explained in a deposition that he did actually prepare one in April, 1997 but that since he could not bear to talk to me to review it, he gave it to the Associate Director of Research to go over it with me which he did not Dr. Dunkman never checked to see if I had received it, which I had not. I also requested a job description from Dr Dunkman but one was never presented.

Finally, after Dr. Dunkman had had many discussions with Philadelphia VAMC management about the easiest way to terminate me, the then Acting Human Resource Director suggested a plan to eliminate my position by depleting the funds in my supervisor's accounts Dr Dunkman then carried out this plan.

On April 29, 1998, a letter from one of the studies indicated that the research funding would cease if Dr. Dunkman decided not to enroll patients. While Dr Dunkman alleged that management asked him not to enroll patients in this study, it was clear that he chose to cease enrollment and eliminate his funding. This study was terminated at the PVAMC and the research patients were transferred (in September 1998) to the Hospital of the University of Pennsylvania where Dr. Dunkman was also on staff.

The initial letter from the Cooperative Studies Center (COOP) indicated this action was being taken due to the investigations instigated by Dr. Dunkman's research nurse. This sentence was later changed in a subsequent letter to try and hide the fact that their actions were in retribution for my voicing concerns about wrong-doing at the PVAMC. Both letters were sent not only to the Philadelphia VAMC but to other hospitals such as the University of Pennsylvania, further damaging my career.

Armed with the COOP study center's letter and an unverified statement showing that one of Dr. Dunkman's many funds had only $2,000 in it, Dr. Dunkman held a meeting with the Acting Director of the Hospital, Mr Michael Sullivan. Mr. Sullivan agreed to terminate my position. In the termination notice of my employment, I was informed that I (as well as my co-worker) was being terminated due to lack of research funds. After termination of my research nurse position, my co-worker was re-hired into the clinic to perform the duties of the research nurse position from which I had been terminated Dr. Dunkman tried to justify this by alleging that he paid my co-worker with pharmaceutical company money, not federal funds Dr. Dunkman testified that he had planned to find a way to re-hire my co-worker and informed the co-worker of this prior to our termination

Prior to and after my termination, I applied for Philadelphia VAMC nursing positions. I asked Human Resources to notify me of any available nursing positions within the hospital I had filed a universal nursing application for employment and had specifically applied for several open positions of which I was aware. I was not considered for the open positions or notified of any other positions or re-hired because I was being retaliated against for my reporting radiation safety concerns and clinical research violations within the Philadelphia VAMC

I am now living with the aftermath of having tried to protect my patients' health and welfare. My reports of impropriety and wrongdoing have left me without a job to support myself and have damaged my career irreparably. I went into nursing to help people. I felt my work in the clinical research area could accomplish helping millions of people by developing new technology for those of us that suffer with incurable illnesses.

The sick, my patients, committed themselves to me and the medical professionals at the PVAMC. My patients implicitly trusted that their welfare would be protected and the truth about the risks of the research studies would be told to them. From my perspective, this was not happening in the clinic where I worked. I stood firmly for the rights of the patients and gave them the respect and care that is deserved by any individual, especially our veterans. My efforts have righted some wrongs but I have suffered greatly for coming forward.

I am here today to ask only one thing of this committee. I ask that the medical professionals who stand up for the patients' rights be protected and not have to suffer. Those who want the truth to be known and try to abide by the government's rules and laws set up to protect people should be applauded, not retaliated against and fired

Remember, we will all be patients someday and will want to commit our trust to our physicians and nurses who care for us. If a whistlebower/nurse stands up for our rights, I would hope that we would want them to be praised, and not to endure untold suffering, as I have in the past years

Thank you for your invitation to speak to you today, and for your concern for the health and welfare of our nation's employees, patients and veterans Your concerns should be commended.

Joan Ellen Pastor, RN, BSN, BS

Education

Bachelor of Science in Nursing — Widener University
1994 — Chester, PA

Bachelor of Science in Chemistry — Muskingum College
1981 — New Concord, OH

Professional Organizations
Drug Information Association
Association of Clinical Research Professionals

Professional Experience

Philadelphia VAMC — **1995 to 1998**
Cardiology Clinical Research Clinic
Philadelphia, PA

Clinical Research Nurse
* Assisted in determining appropriate and reasonable care for clinic patients.
* Managed and coordinated multiple research protocols.
* Established procedures for screening potential research subjects for all research protocols.
* Increased the enrollment in the research clinic and studies through instituting a log for screened patients
* Developed patient educational literature to increase patient medication compliance
* Monitored the patient study files and submitted data to assure accuracy of the submissions to the Sponsor.
* Learned and adhered to all FDA Regulations and Good Clinical Practices.
* Developed promotional materials using the computer.
* Developed an in-house presentation to the Nuclear Medicine Technicians, Physicians and Fellows.
* Arranged and Coordinated an Educational Program for the Cardiology and Pulmonary staff.
* Developed a training film for the MV02 exercise equipment in Cardiology.

MCP Hospital — **1995**
Philadelphia, PA

Critical Care Nurse
* Passed the Critical Care Course offered at Medical College of Pennsylvania
* Completed all of the requirements and passed the Trauma Course

Zeneca — **1988 to 1993**
Wilmington, MA

Technical Sales
* Awarded outstanding sales person of the month, many months, and was awarded bonuses for performance.
* Managed Million of dollars of sales in five states.
* Educated and coordinated sales with the distributors of specialty products to the Mid-Atlantic Region.

- Analyzed markets and product characteristics to determine the needs of the clients and niche markets.
- Negotiated contracts and terms of sales to large corporations.
- Developed Travel, Expense and Sales Budgets for the Mid-Atlantic Region.

Mobay Chemical — Pittsburgh, PA
1983 to 1987

Market Development Representative
- Transferred new product technology from Europe to the United States.
- Implemented computer programs to analyze sales against budget monthly
- Developed product literature and sales tools.
- Expanded potential markets for products through influencing regulation changes of specifications.

Computer Skills Proficient in Microsoft Office Products, Internet Research, Web Page Design and Development

References Available upon request

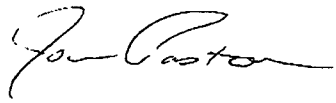
Joan Pastor, BS, BSN, RN

Biographical Sketch

Joan Pastor holds Bachelors degrees in both Chemistry and Nursing and has attended graduate classes towards a Nurse Practitioner degree. She has worked in Clinical Research in Cardiology at the Philadelphia VAMC Joan has served as a speaker for various organizations, including the Association of Clinical Research Professional (ACRP)

Federal Contracts Related to Testimony Subject Matter

I am not being paid by any federal grants or contracts at this time



STATEMENT OF
EARL DICK, M.D.
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
MARCH 11, 1999

Mr. Chairman, my name is Earl Dick. I am a physician employed at the Harry S. Truman Memorial Veterans Hospital in Columbia, Missouri. I am appearing before the Subcommittee in an individual capacity. I am here to speak to the way the VA deals with people such as me. As tragic and illegal as the retaliation and reprisal has been to my career, it is more horrifying to me to recognize that the VA has institutionalized retaliation and reprisal as a way of doing business. I want to express my appreciation for the invitation to provide my Testimony and Statement to this Subcommittee.

I currently have the title of the Associate Chief of Staff for Education; however, from January of 1989 until August of 1994 I was the Chief of Staff for that facility responsible for all the clinical services except nursing and pharmacy.

I believe some background relevant to me is appropriate.

I am a board certified psychiatrist.

From July 1970 to October 1973 I served as a Lieutenant Commander at the U.S. Navy Hospital, Philadelphia. While serving at that hospital, I received a security clearance in order to provide treatment to returning navy fighter pilots who were captured and tortured in North Vietnam.

I served as: President, Eastern Missouri Psychiatry Society, 1982 to 1983 and President, Missouri Psychiatric Association, 1983 to 1984.

I served as a member of a task force convened to draft a revised Mental Health Code for the State of Missouri until that Code was enacted on January 1, 1979.

In 1981 the VA sponsored me to be one of its attendees to the 59th Interagency Institute for Federal Health Care Executives.

The VA has awarded me Certificates of Appreciation and a Commendation, "FOR AN ACT OF HEROISM, 15th August, 1985.

During my tenure as Chief of Staff the hospital received from the Joint Commission on the Accreditation of Healthcare Organizations a three year accreditation (the longest possible) effective June 1, 1992 and a Summary Grid Score of 94. This was the score highest received by the hospital to that time.

I am here to speak about the reprisals I experienced from officials at the Harry S. Truman Memorial Veterans Hospital and the Department of Veterans' Affairs for the disclosures which I have made. I believe what happened to me and Drs. Adelstein, Christensen and Simpson represent the culture of retaliation and reprisal used within the VA.

Retaliation and reprisal begins with actions which management perceives to be threatening. In my case it was the result of my not participating in the cover-up of patient murder in 1992. By September 1992 I was convinced that, independent of the excellent medical and nursing care at our facility, 11 to 40 patients had been murdered. Drs. Adelstein, Christensen, Simpson and myself continue to believe that to be the case and as a result of our beliefs and the

actions we have taken, all of our careers have suffered. The Agency position has been and continues to be that there is no evidence of murder. In a trial brought against the VA by one of the families, the Honorable Nanette K. Laughrey, United States District Judge stated in her ruling from the bench in August, 1998 (page 8 lines 20 -23), "Finally, I also find that even absent the testimony about codeine, there is sufficient evidence for me to believe, and I do believe, that Nurse Williams killed Elzie Havrum."

The epidemiology of the deaths demonstrated murder and was key to understanding what had happened. I was responsible for the Regional Site Visit Team, the FBI, and the Assistant Inspector General for Healthcare Inspections receiving presentations and explanations of the epidemiology. As Chief of Staff, I did not cooperate and support the cover-up even though, from my knowledge of the VA, I knew I was placing my career at risk. I learned that, when detrimental information became public the VA retaliated against me as I had been the Chief Medical Officer of the facility and thus a traitor to the system for not controlling other professionals and not participating in the cover-up.

Following those disclosures in 1992, I received lowered proficiency reports and continued harassment by then Hospital Director, Joseph Kurzejeski. This culminated in 1994 when I was forced from the position of Chief of Staff by threats, including loss of employment, from Mr. Kurzejeski, who was aided by the then Dean of the University of Missouri School of Medicine, Lester Bryant. I agreed to become ACOS/E and found that Dr. Bauer, who had been sponsored by Dean Bryant for the Chief of Medicine, attempted to have the construction of an office for me canceled.

In the Spring of 1995 I made disclosure to the OIG of the events that had happened in 1992. In May 1995, I learned of a plan to relocate me from my office space, which subsequently occurred My old office space has been used primarily for storage until the present time Dr. Bauer continued to provide me lowered proficiency reports. In August 1995, I made further disclosures by providing a multi-ringed Binder, which was used at the May 14, 1998 Hearing of this Subcommittee, containing extensive documentation of the role of Mr Kurzejeski and Region concerning the murders and cover-up to a staff member of this Subcommittee. In the fall of 1995 I received a letter notifying me of a proposed 30 day furlough. To my knowledge I was the only physician at the hospital to receive such a letter, and experience a brief furlough.

In January of 1996 I was given a copy of a plan to abolish the ACOS/E position In August, 1996, within six weeks of my filing with the Merit System Protection Board, I was told by Dr. Bauer of a change in work responsibility, that 90% of my time would be as a staff psychiatrist. This proposed change and the plan to abolish the ACOS/E position was in fact effected by a series of memoranda from Director, Gary Campbell in 1998.

Continuing my activity as an active whistleblower, in 1997 I cooperated with the Office of Special Investigations of the General Accounting Office in their investigation of the VA OIG report initiated by this Subcommittee. The GAO Report titled, "INSPECTORS GENERAL VETERANS AFFAIRS SPECIAL INQUIRY REPORT WAS MISLEADING", stated on page 3, "Therefore, the Special Inquiry's conclusion was not supported by work done or evidence collected and is misleading."

The memoranda notifying me of further demotion were transmitted to me prior to my attending the Subcommittee's Hearing on May 14, 1998 and I believe were part of the VAs response to the highly critical GAO report. Immediately upon my return, Director Campbell clarified his assignment of me to the Mental Health Service Line, and the change in my supervisor. He removed the program assistant from my supervision. Earlier he had approved my reassignment from

the Chair of the Education Council to an ex-officio member. I suffered a demotion.

In summary·

I made disclosures to a Regional Site Visit Team, and to the FBI regarding the 11 to 40 patient murders at Columbia. I made disclosures to the Assistant Inspector General for Healthcare Inspections, the VA Office of Inspector General, the GAO Office of Special Investigations, and to this Subcommittee regarding the 11 to 40 patient murders at Columbia and the cover-up of those murders. As a result my career has been demolished. The retaliation and reprisals against me have damaged my professional reputation, lowered my proficiency reports, caused me to lose office space, chairmanship of a council, removed my program assistant, and led to my assignment as a mental health physician. Thus I have suffered demotion.

My experience is reprisal and retaliation continue even with changes in Hospital Directors Thus VA's statement of new management is and has been meaningless.

Based on my personal experience, I would urge this Committee to discuss reform for the VA to end the VA culture of reprisal, retaliation and cover-up The lowest burden of proof should apply to the whistleblower. The Agency burden of proof should be the highest The Agency has far more resources. An individual should be permitted to choose a grievance procedure within the Agency or be permitted to immediately go outside of the Agency. Once a Congressional Committee accepts and uses information from a whistleblower that person should be protected from reprisal in any form. I believe this should apply to those of us here, as well as Dr Simpson, and those who have aided Congressional Committees in the last five years. My personal experience is such that I have no reason to believe that the VA will change its practice of reprisal, retaliation and cover-up. I can only conclude this represents the culture of the VA. Sadly, I believe change must come to the VA through outside action.

Chairman Everett, there is a price to telling the truth. I and my family have paid an emotional price as well as a loss of income when I was forced from the Chief of Staff position. I and Drs. Adelstein, Christensen and Simpson have suffered significant emotional trauma not only from the retaliation and reprisal but from the knowledge that these patient murders have gone unacknowledged and free of accountability. As a result of retaliation and reprisal, I have suffered financial loss of income and cost of defending myself, as has Dr. Adelstein, Dr. Christensen, and Dr. Simpson.

Chairman Everett, there is a price for not telling the truth. I believe that the cover-up of these patient murders not only prevented criminal prosecution but has prevented the Hospital and VA from acknowledging and accepting responsibility for what occurred. The families of the veterans are left with continuing uncertainty. Without accepting responsibility how are the Hospital and the VA able to assure the patients entrusted to it, that it will not reoccur?

Chairman Everett, thank you. I would like the Committee to know and remember;

The cost of truth in the VA is formidable.

TESTIMONY OF EDWARD H. ADELSTEIN, M.D., D.V.M.
BEFORE THE UNITED STATES CONGRESS
HOUSE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OF THE
HOUSE COMMITTEE ON VETERAN'S AFFAIRS

March 11, 1999

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE

My name is Eddie Adelstein. I am a pathologist at the Harry S Truman Veterans Hospital in Columbia, Missouri and have worked there since it opened in 1972. I also am a licensed Veterinarian and serve as Deputy Medical Examiner of Boone County.

HISTORY OF VA ADMINISTRATION, PRACTICES AND POLICIES

Mr. Kurzejeski was the Director when I was chosen as Chief of Laboratory Service in 1979. He had already established a reputation as an erratic non-programmatic autocrat, who rewarded his friends and punished his enemies. Reprisals were common. Although numerous attempts were made to remove him from this position, he was strongly supported within the "good old boy network," so clearly defined within the VA administration. He tried, unsuccessfully, to force me to hire an unqualified individual for a critical position in the laboratory, where I learned that "lying" was an acceptable administrative tool, that both he and his administrative staff were capable of using. Thus began my introduction into the rules of reprisal that permeate this institution. It is clear that for cover-ups to occur, no actual spoken conspiracy is necessary. No matter how heinous the crime, and the resultant cover-up, everyone knows that if you tell the truth, you will be punished, but if you take part in the cover-up you will be rewarded by promotion and considered a loyal team player with a bright future within the VA system. This was evidenced by the fact that many involved administrative people, including Mr. Kurzejeski received promotions or bonuses as a direct result of their actions regarding the 4E deaths. Clearly individuals who demonstrate principles of high integrity and honesty will not be placed in critical administrative positions. Under this selective system, it is not surprising that serious ethical problems continue to plague the VA administration.

The principles of the new VA under Dr. Kizer have also contributed to this punitive environment, when his first words to the VA were "If you think your job is secure, think again." Change has not been produced by rational cooperative actions, but by fear and reprisal activities.

In spite of these problems, I choose to work at the VA because it was the last altruistic health care delivery system and I felt honored to take care of Veterans who risked their lives to save America. We were relatively unencumbered by profit motive and teaching and research opportunities were plentiful. That paradigm has shifted.

BACKGROUND INFORMATION ON INCREASED NUMBER OF SUSPICIOUS DEATHS ON 4 EAST

In the summer of 1992, I was the acting Chief of Staff at the hospital when I was informed that nurses were complaining that an increased number of deaths was associated with a single male nurse. The quality assurance program had not gathered any data and I asked Dr. Gorgon Christensen, a well trained hospital epidemiologist and his research colleague, Dr. Andrew Simpson, to review the data and establish statistical correlations. They worked quickly with myself and Dr. Earl Dick, the Chief of Staff and determined that these deaths were associated with a single

nurse and all evidence pointed strongly to the murdering of Veterans within our hospital. It was only when Dr. Christensen, facilitated by Dr. Dick, met with a blue ribbon panel of respected VA directors and Chief of Staffs against the orders of Mr. Kurzejeski and was told that "he was a foolish young man to be here" did I begin to understand the lack of ethics that permeates this organization. Although, they clearly understood the implications of the possible murder of up to 40 patients, they also understood the implication of "telling" and as a group made the choice to "cover up". The failure of Dr. Dick, to control Dr. Christensen, labeled him a trouble maker and a non-team player. For this action, he was threatened by the Director.

In spite of numerous attempts to contain these events within the institution, eventually through the efforts of Drs. Christensen, Dick, Simpson and myself, extensive investigations have taken place. When we disclosed and reviewed our findings to The OIG of the VA we were told by Dr. Alastair Connell, the Assistant Inspector General for Healthcare Inspections, that we were now all protected under the Whistle blower protection act. I remember that very vividly because I was offended both by the name "whistle blower," and that as the Deputy Medical Examiner, I was only doing my job. It is interesting that in an affidavit Dr. Connell denies that he made that statement.

The OIG reluctantly carried out a delayed investigation, produced a flawed, dishonest report, and was rightfully criticized by the GAO report. This report in May of 1998 stated the OIG report was misleading.

The GAO noted that the OIG report presented conclusions not based on evidence, never actually investigated the cover-up and misrepresented facts. Although the GAO investigators did not believe that a "cover up" had occurred within the OIG, those of us from rural Missouri would have felt that the work "Misleading" should have been replaced by "Lying, and cover-up". Apparently, we will never understand the wordsmithing of the Washington beltway.

In August of 1998, I testified in a civil suit brought against the United States of America by the Plaintiff, Helen Havrum, who was the wife of one of the 4E patients who died. All other suits had been successfully repulsed by the VA legal team and Justice department. After hearing the evidence the United States District Judge Nanette Laughrey ruled that the preponderance of evidence was so great, that she faulted the VA for failing to protect Mr. Havrum, when they knew or should have known of this danger, and that in her opinion the witnesses for the plaintiff were credible, but the witnesses for the FBI were not credible and self-serving and the she stated clearly, "Mrs. Harvrum, I believe that Nurse Williams killed your husband with an injection of codeine one hour before his death." She awarded the plaintiff $450,000. This decision is presently being appealed. Again in words that we understand in rural Missouri, I would paraphrase her by saying "A massive cover-up occurred within the entire VA health care organization, and that the evidence put forth by the best experts of the FBI were not believable." It was during my testimony that I gave evidence that the VA organization was well aware of the possibility of 40 deaths, that Jessie Brown, himself or his office had determined that this nurse would never again work in a VA hospital suggesting to me that they knew that they had a serial killer, but not only would not take responsibility but would allow this nurse to have the opportunity to hurt or kill other patients.

In a letter dated September 8, 1998, Mr. Everett wrote a letter to Mr. West, Secretary of Veterans' Affairs asking for concrete actions and responses to questions regarding VA employees: Gorgon Christensen, M.D.,Earl Dick, M.D., Edward Adelstein, D.V.M.,M.D. and W. Andrew Simpson, PhD. In this letter asking for specific information regarding VA's whistle blower protection and policies regarding the above, he states "On a number of occasions I have stated my belief that the VA suffers from a culture of tolerating favoritism, cronyism, harassment and reprisal..... Reprisal can be as subtle as it is ugly. To the best of my knowledge no written report has addressed this pivotal letter. I would propose to document the following acts of reprisal as they pertain to the above VA employees. They are as follows:

Campaigns of disinformation

The two most flagrant examples include:

1. The assistant to the Chief of Staff, telling everyone that Dr. Dick was "mean" and "incompetent". Dr. Dick was not given the option of replacing this individual with one who would support him.
2. The administrative staff systematically informed the majority of VA employees that our action to expose the VA for failure to protect patients would result in closing of this hospital and that we, the whistle blowers, would be responsible for losing their jobs. This form of reprisal still continues.

Threats to job security

There are many examples of this. In general due process as clearly outlined by regulations are not followed. Examples include the following:

1. Mr. Kurzejeski collaborated with the Dean of the School of Medicine to pressure Dr. Dick from his job, because he supported the disclosure of the 4E deaths. This pressure became so intense that the health of Dr. Dick was compromised and he yielded to the daily cruel harassment produced on both sides of the street. He agreed to step down and his medical career was effectively destroyed. He was replaced by Dr. John Bauer, the private pick of the Dean, as 50% of the search committee found this appointment unacceptable. He continued to harass Dr. Dick in an effort to drive him from the VA hospital.
2. Dr. Bauer took multiple actions against Dr. Christensen, both professionally and personally and while not directly involved in the 4E deaths took action to prevent Dr. Christensen to report this nurse to the Missouri Board of Nursing.
3. He, I was informed, attempted to get the Dean to have me fired.
4. Dr. Simpson, after suspiciously losing his grant support from highly regarded research activities, lost his VA position as an associate career scientist and the University took multiple punitive actions against him as he was a tenured employee at the University of Missouri.
5. When I was preparing affidavits to support Dr. Dick, I was interviewed by a VA lawyer, Mr. Burke. He called me at home the next morning at 6:45 a.m. to inform me that he needed me to sign an affidavit of our conversation. When I explained that I had already written an affidavit and would not sign his, he informed me that he would have the Director order me to sign and failure to do so would threaten my job. I challenged this logic and never heard from him again. I did however consider it intimidation.

Recruitment of professionals to take action against whistle blowers.

In this environment of reprisals, there are always individuals who see this as an opportunity to advance their careers. This is encouraged by the administrative staff and there are many examples where this occurs.

1. Dr. Christensen was not allowed by Dr. Bauer to bring in an administrative assistant that he could work with, but instead was ordered to hire an individual loyal to Dr. Bauer, who would serve to report back any events which could be used against Dr. Christensen. This resulted in an investigation from the outside which did not follow due process and had clearly an agenda to destroy the career of Dr. Christensen.

2. Individuals from the research service reported to the director the theft of a narcotic attributed to me. These charges were unfounded. This was done, I believe, to curry favor with University and VA administrative officials.

Evaluations

This is the most traditional method to punish whistle blowers and in general was applied to all of us. These steps were seen as prerequisites to dismissal. In some instances they were enormously cruel and ignored due process. They are too numerous to document.

SPECIFIC ACTS OF REPRISAL TAKEN AGAINST ME FOR MY TESTIMONY REGARDING THE SUSPICIOUS DEATHS ON 4E

On October 6, 1997 I gave truthful deposition in the Helen Havrum, v. United States. My deposition was 143 pages in length. Until I testified in the trial of Elzie Havrum, both as a pathologist and as a Deputy Medical examiner, I could view the reprisal phenomena with some degree of detachment. Certainly, my evaluations had gone down, I had been removed from those committees where honesty and integrity would be considered a liability. My research grant was turned down, and simple protocols were being challenged by the research animal committee, but in truth those might have been innocent events, but unusual.

I received a letter from our current Director, Mr. Gary Campbell on June 17, 1998 stating "I am specifically concerned about your interaction with a representative of the news media without first coordinating the interview with the facility Public Affairs Officer. I am also concerned that you apparently did not confine your remarks to subjects and activities under your immediate control or supervision."

It goes on to say,"I recognize that you have a somewhat different status in relation to the 1992 events...that is a unique situation and does not allow you license to comment on other subjects of which you are not responsible." I responded that "isn't is paradoxical that we take care of those people who risked their lives to save America for the very principles of freedom of speech." I viewed that letter as a warning.

In general, since I became a whistle blower regarding the 4E deaths I am not privileged to speak to the press from my office in the VA or from the facilities of the University of Missouri. However, I was encouraged that someone is reviewing the draconian rules and regulations put forth by the new VA as the VHA directive 98-052 now clearly states that physicians can, when requested, express opinions and complete forms for VA patients with respect to patients' health, employability, degree of disability and requirement for licensing. A small victory for freedom of speech.

In August of 1998, I gave extensive testimony in civil suite against the government which led to the ruling that the VA hospital had failed to protect its patients and that Mr. Havrum had been murdered. The lawyers for the VA and the Justice Department were very angry and refused to speak to me after the verdict. Further they asked for a rapid transcription of my testimony.

Shortly after the Judge ruled against the VA and the FBI, Mr. Wu and an associate from the Subcommittee on Oversight and Investigations met with the local director, Mr. Gary Campbell to counsel him regarding this recent decision and to suggest that he form a task group to prevent this from occurring again. In spite of this meeting, no task force has yet been formed. I learned that at this meeting Mr. Campbell suggested that I had a "drug problem." I had no written documents of this charge, but believed that this was related to asking for and getting permission to borrow from the dog laboratory some Sleep-a-way, a class II controlled substance used to euthanize animals in 1996. I perceived that as a kind of poorly defined threat.

On August 31, 1998, I was at home on a documented leave, when I received a phone call requesting me to appear at an Investigatory Board session on September 2, 1998, at 11:00 a.m.
I was not told by phone the nature of the investigation, I was not told whether I was a witness or the subject of the investigation. I was not told whether I had the right to counsel. I was not told whether I had the right to present evidence. I did not receive a written notice that any Investigatory Board had been convened. When I came to work on the next day, I was shown documents indicating that I was being investigated for the "alleged theft of a controlled substance".

I initially chose not to take these allegations seriously as they stemmed from an innocent humanitarian act carried out in 1996 which had been well reviewed and I had not received any admonishments or reprimands. This was based on me asking for and getting permission to use 10 ccs of a drug to euthanize an aged dog, suffering with seizures and cancer without charge to a faculty member after working hours. Since I am a licensed Veterinarian and maintain my own supply at home, it was a simple act of kindness to save me 40 minutes of driving time to perform a kindly act after working hours. In no case had I misrepresented these events.

Dr. Hoyt, the Chief of Radiology, had been interviewed before I was to meet with the committee, and without informing me specifically of their questions, informed me that "This was the greatest threat to my professional career that I would have to deal with." He further informed me that he was approached by one of the board members who told him that he needed to be aware that political agendas at multiple levels were being played out around this investigation. I have secured a notarized statement attesting to this information.

Based on that information I secured an attorney to represent and advise me in dealing with this board of investigation. He advised to quickly obtain affidavits from the animal Lab manager, who willingly gave me the drug, and the faculty member whose dog I euthanized. He also gave me good advice in saying "Don't be angry with this investigative team, they are just doing their job. While they have no qualms in destroying your career, it's just business."

This board was unusual in that it was generated, not at the local level, as is the rule, but directly by our VISN director Mrs. Crosetti and Mr. Campbell. During my testimony, it became clear that this board was not looking fairly for the facts pertaining to their charges, and I provided them with the critical affidavits indicating that I had never stolen anything, that control of these drugs were different from the general class I narcotics used on humans. Further the Investigatory Board was unable to state the legal basis for the allegation of "theft" of define any standard by which I could be judged. They did suggest that my lawyer might look at "21 U.S.C. - 843(c) which prohibits "place(ment) in any newspaper, magazine, handbill, or other publications any written advertisement, and is obviously not the legal basis for the allegation of theft of a substance that is not a Schedule I substance.

The Board determined to take no disciplinary action against me except for a verbal counselling, which I have contested. In an example of convoluted vengeful thinking, they did take action against Dr. Christensen for not taking specific steps against me, even through he had carried out a complete investigation and did not have the authority to deal with this issue.

The timing of this investigation, plus the admitting of the political motive by one of the investigators, coupled with the fact that this had already been investigated and there was no evidence ever presented to suggest "theft" leads me to believe that this is witness reprisal.

Even when these charges were determined to be false, they must be addressed and documented each time I reapply for my medical license. Further, this reckless and callous attempt at witness reprisal for my testimony in the Harvrum trial could perhaps act as a deterrent against me for further testimony involving other patient complaints against the VA regarding wrongful deaths.

Since I testified both as a VA pathologist and the Deputy Medical Examiner of Boone County, I see this as a significant violation of an appointed official with well defined legal responsibilities.

I have sent by mail this complaint to the Federal Judge, Nanette Laughrey, the U.S. Office of Special Counsel and to Mr. Everett, Chairman of the House Subcommittee on Oversight and Investigations.

SOLUTIONS

There is no pleasure in the documentation of wrong doing. Certainly the VA at the highest level must realize that they are sitting on a ticking time bomb, where if not defused by honest actions, it will be revealed that the largest health care system to be fatally flawed and undeserving of the trust of patients. If, as in this case, where there is extensive documentation as to patient deaths, local cover up and obstruction of justice, cover-up and documented lying by high officials and if no action is taken, we must assume that the laws of the land are selectively enforced and our legal structure is without meaning. If these people are allowed to go unpunished, rich in retirement benefits and bonus awards and the truth tellers (Whistle blowers) punished, this will stand as a critical example which will discourage truth and reward deception. This behavior needs to be rapidly reversed. It is no wonder that the people of the United States of America so distrust our government.

I ask you in the name of justice to pursue all aspects of these events. I believe that a grand jury should be convened, individuals deposed, the truth revealed and punishments levied. There will never be a stronger case with this degree of documentation that will send a signal to the VA, the FBI, and the OIG that it is not business as usual. This is an opportunity to redefine government and justice. I can only hope that you and the committee have the strength and will to pursue these actions.

Respectfully submitted,

Edward H. Adelstein, D.V.M., M.D.
Pathologist, Harry S Truman Veterans Hospital
Columbia, Missouri

TESTIMONY OF GORDON D. CHRISTENSEN, M.D.
BEFORE THE UNITED STATES CONGRESS
HOUSE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
March 11, 1999

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE.

The VA punishes employees, including physicians like myself, who "blow-the-whistle" and expose dangerous practices or criminal activities. I know this because the VA has conducted a campaign of personal destruction against me for the past six years. The VA has conducted this campaign because I chose to do the right thing when confronted with the apparent murder of 40 Veterans by a VA nurse at the Harry S. Truman Memorial Veterans Hospital in Columbia Missouri during the summer of 1992.

I earned the ire of the VA for a number of reasons. First, at the request of the Acting Chief of Staff, Dr. Adelstein, and the Chief of Staff, Dr. Dick, and with the assistance of my colleague, Dr. Simpson, I led an internal scientific investigation that confirmed earlier suspicions that a particular nurse, Mr. Richard Williams, caused these deaths. Next, I pushed the Hospital Director, Mr. Kurzejeski, to promptly inform the police that we suspected murder. Mr. Kurzejeski refused to do this. Instead Mr. Kurzejeski blocked the investigation and threatened to take action against me. With the help of Dr. Dick, I pressed for higher VA officials to intercede. But, Dr. Spencer Falcon, the Regional Chief of Staff, and Mr. Albert Zamberlan, the Regional Director, refused to act. Instead, these officials circulated documents throughout the system denying the deaths and claiming my investigation was "flawed." Dr. Adelstein, Dr. Dick, and I then met with Dr. Alastair Connell, the Assistant Inspector General for Healthcare Inspections and complained that VA officials had blocked the investigation, but Dr. Connell did not resolve the problem. In February 1993, I wrote Stephen Trodden, the Inspector General, a detailed letter specifying my charges of obstruction, but Mr. Trodden also refused to investigate. After Mr. Williams left the VA to work at a nursing home, I pressed Mr. Kurzejeski to inform the Missouri State Board of Nursing of the results of the internal investigation implicating Mr. Williams in these deaths. Such notification was in accordance with state law and VA policy. Mr. Kurzejeski refused to do this. Instead, Mr. Kurzejeski – and later the new Chief of Staff, Dr. Bauer – threatened to take action against me if I continued to press this matter. After exhausting all internal avenues of appeal, in January 1995 I publicly aired my concerns of "murder," "obstruction," and "cover-up." The VA, however, denied these accusations. I had to "blow-the-whistle before Mr. Trodden would begin an investigation. Six months later, Mr. Trodden and his subordinate, Mr. Kroll (the Assistant Inspector General for Departmental Reviews and Management Support), released a 66-page report that rejected my claims of "cover-up" and "obstruction."

On October 25th 1995 the Subcommittee on Hospitals and Healthcare conducted a Hearing to receive Mr. Trodden's report. I testified at that Hearing I testified that the report was "wrong and dangerous." Wrong because it was "an incomplete, dishonest, biased, flawed, and

distorted" presentation of the events in Columbia. Dangerous because accepting the report promoted "the cover-up" of these kinds of incidents and endorsed "the VA policy of intimidation of whistleblowers."

This Subcommittee commissioned the United States General Accounting Office to review the investigation conducted by the Office of the Inspector General (OIG). On May 13th 1998 the GAO replied that the OIG report was indeed "misleading." Amongst other things, the GAO noted that the OIG presented conclusions not based on evidence, did not conduct an investigation into a cover-up, and misrepresented the facts.

Finally, on August 7th 1998 United States District Judge Nanette Laughrey ruled on a wrongful death suit filed by the widow of one of the Veterans who died on ward 4 East, Mr. Elzie Havrum. By a preponderance of evidence, Judge Laughrey declared that "Nurse Williams killed Elzie Havrum."

My purpose in bringing up these matters is to remind you that unlike the Veterans Health Administration under the leadership of Dr. Kizer and unlike the Office of the Inspector General under the former leadership of Mr. Stephen Trodden, I speak the truth. Now let me tell you how the VA treats a truth-teller.

Immediately following the 1995 Hearing, Dr. Kizer invited me to Washington for a discussion on how to prevent these incidents in the future. At the conclusion of our discussion, Dr. Kizer surprised me by offering me the position of "Medical Inspector." Dr. Kizer's offer flattered me. I would like to have had the opportunity to fix these problems from within. But after visiting Washington and discussing the position with personnel at VA Headquarters, I concluded that Dr. Kizer's offer was dishonest. As far as I could tell, Dr. Kizer did not support the Medical Inspector's Office and would not hold senior management responsible for their misdeeds, so I declined the position.

When I returned to Columbia, I confronted an increasing office crisis. Under my administration, the Research Service at the Harry S. Truman Memorial Veterans' Hospital had always been a calm and productive unit. This changed when I blew the whistle in 1995. For the first time I faced controversy and angry criticism, prompted – I believe - by my VA superior Dr. Bauer in retaliation for my whistle blowing. I know that Dr. Bauer interfered with my administration of the facility. For example he blocked the selection of an administrative officer for the facility, leaving that position open for ten months. I also know that he met with other Research Service personnel and encouraged them to agitate. I complained about this at the 1995 Hearing and the Chair, Congressman Tim Hutchinson, promised to protect me. Facing more problems, I appealed to the Chairman for help. My appeal backfired. Instead, Dr. Bauer leveled a variety of charges against me, such as poor administration of research funds, mismanagement of the equipment inventory, and unprofessional and disruptive behavior. On August 19th 1996 he asked the Hospital Director, Mr. Campbell, to relieve me of my duties. Instead Mr. Campbell, asked Dr. Feussner, the Chief Research and Development Officer for the VA, to appoint a national panel to review my performance.

Dr. Bauer then confronted me with his charges. Even though I knew the charges were bogus, I believed it would be pointless to try to fight the VA, so I asked if we could negotiate my resignation. Dr. Bauer refused. Over the next two months my attorney repeated this offer to Mr. Campbell and to Dr. Kizer, but they also refused. For this reason, I am convinced the VA intended not to just eliminate an inconvenient employee, but to destroy my professional

reputation. It seems to me the VA intended to destroy the credibility of my accusations by destroying my professional credibility.

On November 6th & 7th, 1996 a national VA Panel reviewed my performance. They did not follow due process. I was not allowed advice of counsel. There was no record of the proceedings. I was not allowed to hear and rebut the testimony against me. I was able, however, through a "Freedom of Information Act" request, to obtain a copy of some of the documents leading up to this review. Before the review, I prepared and submitted a detailed rebuttal to these documents. In the exit interview, the Panel appeared mollified by my rebuttal and agreed that the evidence did not support the charges. I thought that ended the matter, but eight months later on June 23rd 1997, Mr. Campbell presented me an unsigned, undated copy of the Panel report, which ruled against me and recommended my removal. The next day, Dr. Bauer provided me my 1996 annual performance appraisal, eight months overdue, in which he rated me "unsatisfactory," setting the stage for my forced removal. With the help of legal counsel and, I suspect, members of Congress, Mr. Campbell stopped Dr. Bauer's action. Subsequently, Dr. Bauer left the VA and returned to the University of Missouri where he now supervises me as the Interim Chairman of the Department of Internal Medicine.

With the departure of Dr. Bauer, I have calmed Research Service and reestablished our tradition of quiet efficient service. Throughout the ordeal I have kept our expenditures under budget while maintaining full administrative services. In 1997 & 1998 we were one of the few Research Services in the VA system to demonstrate an increase in research funding. In 1998, we set aside $70,000 from operating funds for the recruitment of a new physician investigator to the hospital.

The hospital, however, does not credit me with these successes. Instead I continue to work in a hostile environment. The hospital forced me to give up my position as Chief of Infectious Diseases. Hospital senior management and Dr. Bryant, the Dean of the Medical School, avoid contact with me and ignore my communications. For example they asked me to compile a strategic plan, which I did with considerable effort, then they completely ignored the plan. Senior management and Dr. Bryant have also excluded me from committee appointments, such as the VISN Research Task Force and the VA Hospital-University "Partnership Affiliation Council," which would normally be a matter of course for my position. I am also excluded from all planning and management functions, such as the Hospital's recent actions to obtain funding to expand research space. This management exclusion curtails my influence and signals to all coworkers and colleagues senior management's displeasure. In case any one has missed the message, both senior management and Dr. Bryant, have publicly complained on numerous occasions that the bad publicity – caused by my actions – could close the Hospital, hurt the University, and cause people to lose their jobs.

This past August, in the weeks surrounding the Havrum trial, the reprisals escalated to a new level of activity. On July 10th - while on vacation in Canada - I found a message pinned to my tent to call the office. Believing that a member of my family had died, I returned the call and learned that without explanation or warning Mr. Campbell had vetoed my appointment to the VA Disciplinary Appeals Board. This meant that Mr. Campbell had also cancelled the training I was scheduled to receive the following week in Denver.

After my return to Columbia, I learned that Dr. Adelstein would be facing a Board of Investigation over an incident that had taken place in December 1995. I was peripherally

involved because I had filed a report on the incident with Dr. Bauer a year earlier in August 1997. Apparently Dr. Adelstein asked a Research Service employee for some "Sleepaway" to put to sleep his neighbor's dog. The animal was suffering from cancer and Dr. Adelstein did not have the drug on hand. Dr. Adelstein is also a veterinarian and he sometimes provides small services like this when circumstances demand it. Sleepaway is a long acting barbiturate, which is used exclusively for killing animals, which is why we had some in the research animal facility. The employee gave the drug to Dr. Adelstein and Dr. Adelstein failed to replace the amount of drug he had used. The next hospital drug audit detected the discrepancy, prompting an investigation. The drug auditor apparently resolved the issue, because nothing more happened. My assistant informed me of the event because it occurred in Research Service. I didn't see any reason to take any further action since Research Service was not responsible for the inventory of this drug, Research Service was not involved in the drug audit process, and the drug auditors seemed satisfied the problem had been resolved. Nevertheless, the following August, in connection with another incident, a research employee complained. So I compiled a complete report on both incidents and filed it with Dr. Bauer. I heard nothing more about the matter until the following July, just before the Havrum trial.

The Havrum trial was held between July 27th and August 8th. (As an aside, during the trial, a nurse provided sworn testimony that the hospital used Boards of Investigation to attack employees rather than for legitimate fact finding.)

By direction of senior management, without my knowledge and before the Board of Investigation had been convened, on August 20th the hospital reported to the Drug Enforcement Agency the incident involving Sleepaway and Dr. Adelstein. In filing the report, the hospital claimed this incident had just come to their attention. Naming me by name, the hospital said I had failed to report this incident to them. This was a lie. The hospital's drug auditor had picked up this incident in January 1996. If it required reporting, the auditors should have reported it then. I personally had reported the incident to Dr. Bauer, the Chief of Staff, in September 1997. If the report required filing, it should have been reported then. The hospital knew about this incident for at least 11 months before filing this report.

On July 22nd Mr. Campbell asked Mrs. Patricia Crossetti, the VISN Director, to appoint a Board of Investigation for the Sleepaway incident. The Board members received their appointment letters on August 27th and on September 1st 1998, Mr. Campbell signed a letter from Mrs. Crossetti expanding the scope of the Board of Investigation to include my performance. On September 1st, the VISN conducted a Board of Investigation. The Board asked me to testify, but they did not warn me that I had been made a target of this investigation. I did not have advice of counsel, I was not allowed to submit evidence in my favor, and I was not prepared for the Board's accusatory questioning.

In the end, the Board concluded that I should have informed my superiors of this incident and recommended that I receive written and oral counseling, which I later received. The Board did not criticize anyone else in this matter besides Dr. Adelstein and me.

After this incident the VA took a different approach to attacking me, reorganization. Our VISN has only three Associate Chief of Staff for Research and Development positions: St. Louis, Kansas City, and Columbia. On November 5th, our office received a proposal from Mrs. Crosetti's office that research in the VISN be reorganized into East and West "orbits." This reorganization would eliminate Columbia. The proposal, however, encountered heavy criticism.

My understanding is that we will be reorganized into East and West orbits, but Research Service and the ACOS/R&D position in Columbia will be left alone.

It is impossible to fight a six-year campaign with the Federal government and maintain high level professional productivity as a scientist, physician, educator, and administrator, but I have enjoyed success. I continue to publish research articles and I have obtained a Merit Review research grant. I regularly receive top scores for my teaching. My physician colleagues selected me to be added to the list of "Best Doctors" and my University colleagues elected me to the faculty senate.

This ordeal has taken a heavy personal toll. The monetary cost has been ruinous. I have spent $43,000 in legal expenses plus another $8,000 in miscellaneous expenses (mailing, photocopying, telephone calls, FAX transmission, etc.). The thing that hurts the most is the impact this has had on my family. My daughters have grown-up while their father has battled the VA over murders and cover-up. The battle has embarrassed them and intruded on their childhood. The battle has taken me from my wife and daughters. It has also hurt my friends and coworkers. Some have become targets simply because they were associated with me; others like Dr. Andrew Simpson, seem to have become targets because they also helped me in fighting this issue. For example, during this period of time Dr. Simpson unexpectedly lost his VA research funding and had to transfer from the VA to the University of Missouri. At the University he encountered more problems, such as proposals to move him to a new location 200 miles away or cut back his 12-month appointment to a nine-month appointment. These proposals originated in the office of the Dean of the School of Medicine. Perhaps they thought that if they could force Andy to leave Columbia I would also leave.

I will not leave. I will finish this. I insist that the VA cease behaving like a public monarchy populated by little emperors and queens. I insist the VA start conducting its business like a public service, according to public law, staffed by public servants who "put loyalty to the highest moral principles and to country above loyalty to person, party, or government department.

STATEMENT OF THE

DEPARTMENT OF VETERANS AFFAIRS BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

MARCH 11, 1999

Mr Chairman, and members of the Subcommittee: Thank you for the opportunity to appear before you today to share information on the policies and protections afforded to Department of Veterans Affairs employees who "blow the whistle" or who otherwise believe they may be subject to retaliation for disclosures or complaints.

Avenues available at VA for redress of whistleblower retaliation claims

At VA, as is true at all Federal Departments and agencies, there are a number of avenues, created by statute and regulation, which an employee may use to seek redress of reprisal as a result of whistleblowing activities. Outside the EEO arena, an employee's choices for raising a claim of retaliation include.

1. **The Merit Systems Protection Board** (MSPB) – This avenue is available to employees who have received adverse personnel actions appealable to the MSPB. Employees may raise claims of whistleblower reprisal in their MSPB appeal. All VA employees are informed of this appeal right and are provided with an MSPB appeal form at the time that the adverse action is taken. That form specifically solicits information on any whistleblower claim the employee wishes to rise at the MSPB. An employee who is dissatisfied with the MSPB's final decision may appeal to the U.S. Court of Appeals for the Federal Circuit
2. **Office of Special Counsel** (OSC) – Employees may file claims with OSC if they believe they have been subjected to any prohibited personnel

practice, including reprisal for "whistleblowing," even in cases which are not otherwise appealable to the MSPB (e.g., reassignment, non-selection. title 38 disciplinary actions). If after review and/or investigation, a claim is dismissed by OSC, employees may, and are informed by OSC of their right to, appeal to the MSPB through the filing of an Individual Right of Action appeal. Again, MSPB decisions may be appealed to the Court of Appeals for the Federal Circuit by employees dissatisfied with the result

3. **VA Office of Inspector General (OIG)** – The Inspector General is available to receive complaints of whistleblower reprisal from VA employees at any time. If the OIG makes a finding of retaliation, management is required to concur or disagree with that finding. The employee may, at any time, file the claim with the OSC (or, if available the MSPB).
4. **Title 38 personnel action appeal** -- Reprisal issues may be raised in the statutory title 38 disciplinary procedures. Title 38 employees (VHA health care professionals) are also entitled to pursue claims of whistleblower retaliation through other procedures including the OSC and an Individual Right of Appeal to the MSPB.
5. **Negotiated grievance procedure** – This avenue is available if a personnel action has been taken which is grievable under a negotiated grievance procedure contained in a labor-management collective bargaining agreement. In this regard, two national collective bargaining agreements (AFGE and NAGE), covering approximately 120,000 VA employees, contain provisions which give employees protection from reprisal. Employees may elect to use either this procedure or the previously described statutory procedures, but they may not use both.
6. **VA's administrative grievance process** – This avenue is available to non-bargaining unit employees in covered cases, which are not otherwise appealable within the VA. Use of the agency grievance procedure does not preclude going to the OSC

There are additional avenues employees may use when they believe they have been retaliated against due to their exercise of rights under the law. For example, a claim that an employee has suffered reprisal due to his exercise of rights under the Federal Service Labor-Management Relations Statute may be included in an unfair labor practice complaint. The same is true of the Occupational Safety and Health Act, environmental laws and other Federal statutes. And, as you know, VA is currently implementing its new statutory procedure for issuing and reporting final agency decisions on EEO complaints, including claims of reprisal for the exercise of EEO rights. Of the 821 final decisions on the merits issued by VA's new Office of Employment Discrimination Complaint Adjudication (OEDCA) to date, 26 found discrimination. Ten of those 26 decisions (approximately 38%) included a finding of retaliation because of the complainant's prior EEO activity. The Director of OEDCA has reported these ten findings of retaliation to the Secretary, along with 7 retaliation findings issued by the Equal Employment Opportunity Commission.

Informing VA employees of their rights

This enumeration of avenues of redress illustrates how difficult and confusing they may be to the employee. The Department acknowledges that there is room for improvement in insuring that the VA workforce is fully informed of the existence of all these procedures and that employees are aware of the choices available to them. VA facilities have significant authority in managing their Human Resources programs, including determining the manner in which employees and supervisors are informed of the protections against whistleblower reprisal. Although copies of the national agreements mentioned earlier have been distributed to all bargaining unit employees and supervisors, we recognize that the uniformity and consistency regarding what and how the information on this topic is provided may need improvement. Employees are informed of their whistleblower rights and protections in ways that vary from facility to facility – through information posted on bulletin boards, or distributed in employee handbooks, facility newsletters and employee orientation materials. Actions are

now underway to improve our information dissemination process and to make it more formalized and consistent.

First, the Secretary of Veterans Affairs has issued additional guidance to both managers and employees on whistleblower rights and the avenues of redress available to those who believe they have suffered reprisal due to whistleblowing activities. This guidance consists of a Memorandum to All Employees and a Memorandum for Administration Heads, Assistant Secretaries and Other Key Officials. In both of these memoranda Secretary Togo D. West, Jr reminds employees about the special review procedures, instituted by VA in 1993, for handling complaints of reprisal. Under these procedures, all investigative reports on reprisal complaints are to be reviewed by management officials above the facility level where the reprisal is alleged to have occurred. This provides the higher level officials with an opportunity to make specific corrective interventions if considered appropriate. The higher-level review requirement applies to all types of reprisal complaints other than those which arise in the EEO process. Since enactment of Public Law 105-114, the Office of Resolution Management (ORM) Equal Employment Opportunity (EEO) counselors provide early intervention in the counseling process by apprising ORM EEO Officers of retaliation complaints that may necessitate the involvement of higher level officials. Further, the Office of Employment Discrimination Complaint Adjudication (OEDCA) refers all final decisions finding retaliation for EEO activity to the Secretary.

In addition, in the memorandum to all employees, Secretary West lists avenues for redress available to those who believe they have been or are being retaliated against for whistleblowing. In the memorandum to senior managers, Secretary West reminds these key officials of their responsibility for protecting employees from reprisal. The Secretary directs that information about whistleblower protections and responsibilities be included in all new employee

orientation programs and supervisory training. The Secretary's instructions will help establish consistent policy and mechanisms for informing employees of their protections

Other steps are being taken as well. VA's Office of Human Resources is creating a page entitled "Whistleblowing" which is linked to VA's home page on VA's Intranet This new page will display a message directing the reader to the fact that it is a new addition. It will contain information about whistleblowing, protections afforded to employees, and links to helpful resources. Although the web site is still a work in progress, the Secretary's memoranda on this subject will be added to it, as will a copy of the MSPB Handbook that provides questions and answers about whistleblower appeals, and links to the MSPB and OSC web sites. VA intends this web page to be a useful resource for employees and managers alike As VA obtains and develops more information on this topic, it will be posted on the web.

VA has also decided that all senior employees will receive annual reminders regarding the rights of whistleblowers and the prohibitions against whistleblower retaliation possibly as an adjunct to their annual required ethics training.

Finally, the Secretary asked two of his senior managers, the General Counsel and the Assistant Secretary for Human Resources and Administration, to establish a team of VA employees to review aspects of the whistleblower and retaliation issues at VA. The initial focus of the group will be on identifying the information needed at headquarters to assess and manage whistleblower protection matters, and how that information may be effectively collected. The team has been appointed and begun meeting. We would be happy to share the team's report with the Committee as soon as it is available.

Opening up a dialog between employees and managers is key

With increasing frequency, employees at all agencies are filing reprisal complaints after they have filed other types of claims or complaints. According to statistics in the Equal Employment Opportunity Commission's most recent (1997) Federal Sector Report on Complaints Processing and Appeals Report, reprisal is the most commonly cited basis for discrimination complaints representing 22% of all Federal complaints, or 15,477. This number has grown, Federal-wide, each year since 1994. At VA, the Office of Resolution Management is finding that miscommunication and misunderstanding between supervisors and complainants often give rise to complaints.

In this area of heightened sensitivities, claims will inevitably occur. We believe that a process that permits open and free communication, by ensuring employees that their concerns will be addressed while at the same time ensuring fairness to managers, is the key to handling such claims. We are at the beginning of this process, and have more to do. We will be effective only when we have a system which encourages employees to come forward to express their concerns and assures that when and if they do, those concerns will be addressed without reprisal.

As you know, over the last two years VA has, under Public Law 105-114, implemented an improved discrimination complaint system. Under that new system, ORM is involved in an ongoing effort of working with VA Administrations and labor partners to develop and implement an Alternate Dispute Resolution (ADR) program. Mediators have been used to help resolve several complaints within the system, some involving allegations of retaliation. The Department as a whole is committed to increasing the ***early*** access to mediators in ***all*** VA workplace disputes.

To this end, VA has negotiated agreements with its labor partners, both at national and local levels. These agreements require labor and management to

jointly develop programs that offer ADR techniques which use mutually agreed upon neutral third parties to help resolve workplace conflicts Roughly 30% of VA medical centers already have jointly developed mediation programs and VA is actively working to increase this number Where these programs are being used effectively, VA has experienced a 70-90% resolution rate ADR can thus substantially assist in obtaining a resolution acceptable to both the employee and the supervisor before a possible retaliation situation arises

VA must and will properly deal with all retaliation found to exist

There are instances where retaliation for protected whistleblowing has occurred. Retaliation may involve direct and substantial actions such as disciplinary action, failing to promote or giving an employee a negative performance appraisal. It may be more subtle Whether subtle or direct, however, VA does not and will not condone such behavior

Supervisors who engage in such behavior will be dealt with appropriately, including the imposition of discipline when warranted Those of higher rank will **not** be treated more leniently VA is aware of the perception by some that the Department has protected members of senior management who transgress in this area Regardless of whether that perception is accurate, any favoritism showed to senior managers would be intolerable. To ensure consistency in how the Department deals with this issue, a requirement was put into effect in March 1997 under which all proposed actions related to conduct or performance problems involving senior officials must be reviewed by the organization head and coordinated with the Office of General Counsel, the Office of the Assistant Secretary for Human Resources and Administration, and the Secretary's office

If retaliation is condoned, or if employees merely *think* it is condoned, they will be unwilling to bring legitimate concerns to the attention of management and will be reluctant to report wrongdoing or waste, fraud, and abuse Such a state of

affairs would deny VA officials the opportunity to correct mistakes and improve operations VA is a high-performing organization and realizes that if it is to stay that way, it must have a competent, professional and fully committed workforce, which serves veterans and their families in an atmosphere free of retaliation. VA will work steadfastly to establish and maintain good faith with our employees.

It will take time to educate our entire workforce, especially one the size of VA, but that is what we intend to do. The results of our efforts may not be fully quantifiable, but our goal nonetheless is to not only protect the whistleblower who has been the victim of retaliation, but also to prevent such retaliation from occurring in the first place. Only when we have achieved that will we be able to maximize our service to America's Veterans.

We appreciate the Subcommittee's focus on these issues. Your attention has required the Department to scrutinize its policies and identify areas that must be improved. We look forward to working with the Subcommittee as we make necessary improvements. We will be happy to answer any questions you may have.

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